

**MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM**

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care for a minor in the event of an emergency. This is extremely important, in that, medical care can not be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

---

*Minor's Full Name*

---

*Minor's Address*

---

*City, State, Zip Code*

---

*Minor's Age*

The undersigned do hereby authorize Christopher Tate/Alison Sigethy or such substitute as he/she may designate as agent for the Undersigned to consent to any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

---

*Parent or Guardian Signature*

---

*Date*

---

*Parent or Guardian (please print)*

---

*Address Parent or Guardian*

---

*Home and Work Phones of Parent or Guardian*

---

*Witness*

---

*Insurer*

---

*Account Number*

---

*Family Physician*

---

*Family Physician's Full Address*