MEDICAL AUTHORIZATION FORM

I, the undersigned, and parent of _____,
hereby authorize the following to bring my child:

Person be authorized	Relationship to child
_____	_____
_____	_____
_____	_____

This person can authorize any and all medical treatment for _____ as they in their discretion see fit. This includes, but is not limited to, treatment to relieve pain and immunizations.

If a person brings in a child and their name is not on this form, we will try to contact the parent to have them fax an authorization to us. If we are unable to obtain, we will not be able to see the child.

This authorization shall be in effect until one year from the date signed.

_____ _____
Mother's signature Date

_____ _____
Father's signature Date

_____ _____
Guardian's signature Date

_____ _____
Witness Date