Medical Authorization Form

I, ____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by medical doctors, hospitals or their authorized designees, as may in their professional judgement be necessary to provide for the medical, surgical or emergency care of my

________________________________ ________________________________.
(relationship) (hereafter "dependent") – Full Name

I further give my consent to ____,
(Favor Academy of Excellence Staff) – Full Name

who will be caring for my dependent for the period _______________ through ________________, to arrange for routine or emergency medical and/or dental care and treatment necessary to preserve the health of my dependent. In the event that my dependent is injured or ill while under the care of the caregiver, I hereby give permission to the caregiver to provide first aid for said dependent and to take the appropriate measures, including contacting the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that the Favor Academy of Excellence Staff attempt to contact me. However, if medical care becomes essential, I give permission to the Favor Academy of Excellence Staff to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the Favor Academy of Excellence Staff on my behalf for the benefit of my dependent, I authorize the Favor Academy of Excellence Staff to request, obtain, review and inspect any and all information bearing upon my dependent's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent during this period.

____
Signature of Legal Guardian Date

____
Address Phone Number

____
Name of dependent(s)

____
Phone Allergies

____
Health Insurance Carrier Health Insurance Policy # and Group #

____
Physician's Name Physician's Number

Physician’s Address

Physician’s Phone