

TO BE NOTARIZED

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I, _____, the parent of _____
(Full Name of Parent) **(Full Name of Child/Children)**
authorize Karen Greene and Staff to obtain medical care for my child in case of
emergency. My permission is given to any hospital or doctor to treat my child in case of
emergency. Permission for treatment will only be given if I cannot be contacted or if
immediate treatment is warranted at the discretion of the attending medical person.

Signed:

(Parent/Legal Guardian)

Date:

(Month/Day/Year)

NOTARY SEAL: _____

NAME OF INSURED: _____

NAME OF INSURANCE COMPANY: _____

POLICY #: _____

**PLEASE PROVIDE A COPY OF YOUR INSURANCE
CARD. (FRONT AND BACK)**