MERIDIAN MD
Family Medical Care

AUTHORIZATION TO CONSENT FOR TREATMENT OF MINOR CHILD

TO WHOM IT MAY CONCERN:
This is to certify that I, _____

_____ _____
(Address) (Telephone number)
Parent/legal guardian of the minor person listed below, do hereby appoint the following individual(s):

_____
(Name) (Address) (Telephone number)
OR

_____
(Name) (Address) (Telephone number)
with the power to authorize and consent to medical treatment and/or the administration of medication and/or anesthetic for the performance of operations or removal of tissue determined to be medically necessary by the attending physician, on the below named minor for the period from _____to _____ inclusive. I also understand that I am legally responsible for any charges/claims resulting from the aforementioned treatment of the below named minor:

_____ _____ _____
(Minor's Name) (Date of birth) (Allergies)

DATE OF LAST TETANUS CURRENT MEDICATIONS

_____ _____

Pertinent Medical Information/History:
_____
_____
_____
(Family Physician)

_____ _____
(Name of Insurance Company) (Name of Insured-Date of Birth-Social Security Number)

_____ _____
(Secondary Insurance Company) (Name of Insured-Date of Birth-Social Security Number)

_____ _____
SIGNATURE OF PARENT / LEGAL GUARDIAN DATE

_____
RELATIONSHIP TO MINOR

_____ _____
WITNESS DATE
SOURCE: IN CODE 16-36-1-6