MEDICAL AUTHORIZATION FORM

We, the undersigned, and parents of _____, hereby authorize _____ , to authorize any and all medical treatment for _____should they in their discretion see fit. This includes, but is not limited to treatment to relieve pain.

A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain in effect until _____.

MEDICAL INSURANCE COMPANY:

MEDICAL INSURANCE ID or GROUP #:

MEDICAL INSURANCE CO. PHONE #:

PEDIATRICIAN:

PEDIATRICIAN PHONE #:

_____ _____

Parent Signature DATE

_____ _____

Parent Signature DATE