

## AUTHORIZATION FOR A PARENTAL SURROGATE TO CONSENT FOR MEDICAL TREATMENT OF A MINOR

TO: Medical and/or Dental Care Provider

I, the parent of the minor child (ren) listed below, hereby authorize the undersigned, noted surrogate, as my agent, to consent to any necessary and desirable medical care needed by the minor child (ren) during my absence from the community. This authorization shall be valid for the period starting at 12:00 am. January 1, 2007 and ending on December 31, 2007 at 11:59 pm.

I understand that nothing in this agreement shall relieve me of any financial responsibility arising from my child (ren's) use of the Medical and/or Dental Care facility or the care provider. I hereby agree, in consideration of the services to be rendered to the below named child (ren), to be individually responsible to pay the account of the care facility and provider therefore in accordance with its regular rates and terms.

Please Print.

Minor's Name/Age	Minor's Name/Age
Minor's Name/Age	Minor's Name/Age
Minor's Name/Age	Minor's Name/Age

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date
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Street Address	City	State	Zip Code
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Home Phone	Work Phone	Cell Phone
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Home Phone	Work Phone	Cell Phone
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Surrogate Information:

Surrogate Signature	Date	Surrogate Signature	Date
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Street Address	City	State	Zip Code
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Home Phone	Work Phone	Cell Phone
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Home Phone	Work Phone	Cell Phone
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