PARENTAL AUTHORIZATION Consent to Medical Treatment for Child

				of
Address				
City		St Zin		
ony am the parent or legal guardian h While being absent from my child	aving legal custody of the ch	ild(ren) listed b	elow.	
mo day	year until	mo	day	year
I have entrusted his/her/their care	e to:			
Name			10-1-12-12-12-12-12-12-12-12-12-12-12-12-1	
Address				
City		St Zip		
I authorize the adult(s) listed abor treatment, and hospital care, to b any physician or surgeon license CHILD'S NAME	e rendered to the child(ren) u	inder the gener	ral or special su icky and/or state	pervision and on the advice of
1.				
Pertinent Medical History				
2.				
Pertinent Medical History				
The state of the s				
3.				
Pertinent				
Medical History				
4.				
Pertinent Medical History				
			Dhasa #	
Child's Doctor Name:			_ Phone #	
Medical Insurance Information:	Policy Holder			
	Insurance Co			
	Policy Number		_ Group #	
This authorization shall only be e responsible for all costs of medic	fective during my absence of al treatment rendered to my	on the dates se child(ren).	t forth above. I	agree to be financially
Parent Signature:			Date	
Witness Signature:			Date	
	Specialty Orthopaedics, PS	C [SO-68 (Rev. 5-10-0	N61)	