MINOR (CHILD) MEDICAL AUTHORIZATION FORM

I,_____, being the parent and/or legal guardian of_____(hereinafter, my child(ren) do hereby authorize_____to seek and obtain medical care for my child(ren) in the event that my child(ren) need(s) medical care.

My child has the following allergies: _____. (if applicable)

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this Authorization.

My health insurance carrier is _____ and my Policy or Certificate number is _____.

Date _____

Signature of Parent (or Legal Guardian) _____

Witness Signature _____

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF _____}

COUNTY OF _____}

On _____ before me, _____
(here insert name and title of the officer)

personally appeared _____

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: _____(Seal)