AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF CHILD

I(We), _____(parents/legal guardians) of _____(full address) make oath and say that I (we) am (are) the lawful guardian(s) of the child(ren) listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.
Child 1: _____(name), _____(sex), _____(age), _____(DOB) and residing at _____.
Current Meds:_____
Allergies:_____
Child 2: _____(name), _____(sex), _____(age), _____(DOB) and residing at _____.
Current Meds:_____
Allergies:_____
Child 3: _____(name), _____(sex), _____(age), _____(DOB) and residing at _____.
Current Meds:_____
Allergies:_____

Health Insurance:
Ins. Co._____ Policy Holder_____
ID#_____Group#_____Claim Address_____

I hereby authorize and appoint_____(name), of _____(address) as my agent(s). My agent(s) may consent to my child's surgical, dental, developmental, mental health and/or medical examination or treatment. Such treatment may include but is not limited to the following: transportation by ambulance, examination, x-rays, diagnoses, hospitalization, anesthesia, surgery, medication and/or transfusion of blood or blood products. My agent may have access to any and all records, including, but not limited to, insurance records regarding any such services.

Our Pediatrician, _____, may be contacted at:
Vickery Pediatrics
410 Peachtree Parkway, Suite 4260 Cumming, Ga. 30041
Telephone: (678) 990 - 2501
Fax: (678) 990-2505

Emergency Contact:
I (we) ____ can be contacted at work or home ____ cannot be contacted ____ will be away from home but can be contacted at _____(phone)_____(alternate phone)_____(address).

Effective Date:_____ **Termination Date:**_____

Parent/Guardian _____**(signature)**
Witness_____**(signature)**
Date_____