

CONSENT AND AUTHORIZATION FOR MEDICAL CARE

I, _____, SSN: _____ (parent, custodial, or guardian) of _____, a minor, hereby appoint

_____ to act in my stead, if the school has been unable to contact me, with power to authorize and consent to medical care and treatment for my minor child, to include admission to a hospital or presenting such minor child to any duly credentialed physician, dentist, or health care provider for any emergency medical or dental treatment or care including, but not limited to, examination, X-rays, necessary surgery, the administration of anesthesia, and the use of drugs or medications as deemed necessary for the health of my child.

Unless sooner revoked or terminated by me, this consent shall expire on: _____

(Signature of (custodial) Parent or Guardian)

(Date)

Witness initials _____