MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care for a minor in the event of an emergency.

*Minor's Full Name*_____

*Minor's Address*_____
*City, State, Zip Code*_____
*Minor's Age*_____

The undersigned do hereby authorize **Aaron Christopher Cantrell** or such substitute as he may designate as agent for the Undersigned to consent to any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

*Parent or Guardian Signature Date*_____

Parent or Guardian (please print) _____

*Address Parent or Guardian*_____
*Home and Work Phones of Parent or Guardian*_____

*Witness*_____
*Insurer Account Number*_____
*Family Physician*_____
*Family Physician's Full Address*_____