

A Friend of the Family[®]

MEDICAL TREATMENT FORM AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR/ADULT

I, (we), the undersigned parent(s)/guardian(s) of the minor(s) listed below do hereby authorize

(Family doctors or pediatrician or emergency room physician in charge at hospital)

(Adult into whose care minors or adults are entrusted)

to act in my (our) behalf to consent to all necessary and appropriate medical treatment, surgery, or hospital care which is advisable by and is to be rendered under the general care of a licensed physician or surgeon under the laws of the State of Georgia. It is understood that this authorization, which is valid indefinitely from the date below unless sooner terminated, is given in advance of any specific diagnosis, treatment, or hospital care, but is given to provide authority and power on the part of my (our) aforesaid(s) to give specific consent to any and all such diagnosis, treatment, and hospital care which the aforementioned physician(s), in the exercise of his (their) best medical judgment, is deemed advisable and is within sound medical practice in the community and is in the best interest of the child(ren) or adult(s). I, (we) assume all financial responsibilities for such care.

<u>CHILD(REN)'S/ADULT'S NAME(S)</u>	<u>BIRTH DATE</u>	<u>BLOOD TYPE</u>	<u>ALLERGIES</u>
-------------------------------------	-------------------	-------------------	------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PHYSICIAN INFORMATION

Primary Doctor

Phone

Address

City

State

Zip Code

Medical Insurance Company

Type of Insurance

Policy #

(Signature of Parent(s) or Legal Guardian)

Date