

**Authorization for Parental Surrogate to Consent
To Medical Treatment for Minor Child(ren)**

Code #352.02 Exhibit 2

I, the parent of the minor child(ren) listed on the **reverse side**, hereby authorize,

 (Type or print Name of Surrogate)

as my agent to consent to any necessary and desirable medical care needed by the minor child(ren) during my absence from the community. This authorization shall be valid for the time period starting at 12:01 a.m. on _____ and ending at 11:59 p.m. on _____.

I understand that nothing in this agreement shall relieve me of any financial responsibility arising from my child(ren)'s use of the medical facilities. I hereby, in consideration of the services to be rendered to the below-named child(ren), to be individually responsible to pay the account of the hospital therefore in accordance with its regular rates and terms.

Parent's Signature	Date: _____	Home Phone (_____) _____
Parent's Signature	Date: _____	Work Phone (_____) _____
Parents' Names Typed or Printed		Cell Phone (_____) _____
Parents' Home Address		
City	State	Zipcode

More information on back of form!

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Child's Name	Birthdate	Allergies	Date of Last Tetanus Booster	Current Medication	Child's Physician

Attach an additional sheet if more space is needed.

Insurance Information

Primary Insurance Carrier:

Name of Insurance Company

Identification Number

Group Number (if any)

Signed (Insured Parent or Guardian of Minor)

Additional Insurance:

Name of Insurance Company

Identification Number

Group Number (if any)

Signed (Insured Parent or Guardian of Minor)