AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT

I, _____ being the custodial parent and/or legal guardian of_____, born _____ in _____,

(Name of child) (Date of Birth) (State)

Do hereby authorize _____

(Printed Name of Authorized Person Accompanying Child)

And/or authorize _____

(Printed Name of Authorized Person Accompanying Child)

To consent to and secure for or on my behalf medical and/or surgical treatment for my child.

The consent of any person listed below shall be the equivalent of consent by us personally and any physician, hospital, clinic or other medical treatment to said child, including, but not limited to, diagnose, treatment, medication and surgery.

This consent shall remain in effect until revoked in writing by the undersigned but not more than sixty (60) days from the date of execution.

The adult person/s authorized to secure for and on our behalf medical and/or surgical treatment for and on behalf of our child are: _____ or _____.

(Printed Name of Authorized Person or Persons Accompanying Child)

PARENT: _____ _____

(Print name) (Signature)

Address: _____ County of_____.

SEAL NOTARY PUBLIC (signature) _____

(Printed) _____

My Commission Expires on: _____ Residing in: _____ Co._____

Received by: _____ of Kids In The Mudd Foundation, Inc. On: _____