Boca Grande HEALTH CLINIC

PARENTAL AUTHORIZATION FOR MEDICAL CARE

We, _____ and _____ _____, are the parent(s) and/or legal guardian(s) of the following named children:

_____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

We hereby authorize any one of the following individuals:

_____ of _____

_____ of _____

_____ of _____

to consent to any and all medical care and attention for these children that is deemed necessary and appropriate by a licensed physician in this state. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care.

We further agree to reimburse the health care provider for the cost of rendering these services. The children are covered under the following healthcare plan:_____

The following information is provided to assist in this care:

Name of Child:_____Age_____

Physician: _____

Allergies: _____

Medications: _____

Handicaps or Illnesses: _____

Signature of Mother: _____ Signature of Father: _____

Date: _____