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Medical Authorization

I hereby authorize _____ (print name of temporary guardian of the person) to initiate, authorize or consent to any medical treatment necessary in said guardian's sole discretion, for the benefit of my child/children_____ _____(name(s), social security number(s) and date(s) of birth of the child/children). I hereby indemnify any third party who relies on this authorization in the interest of encouraging medical personnel to provide medical treatment as requested by the temporary guardian named above.

Further, this authorization shall survive any disability I may suffer and if I do suffer a permanent disability, then the named temporary guardian shall be deemed the permanent guardian of said child/children.

Attached please find evidence of medical insurance (copy front and back of card), I hereby agree to be responsible for any costs of care not covered by insurance. My child/children's primary care physician(s) is/are_____ _____.
(name, phone, address of physicians)

_____ Witness

_____ (print name of parent)

Address:_____

_____

Phone:_____

Email:_____

Social sec # of parent_____

DOB of parent_____