Authorization for Medical Treatment of Minor

Child:	Date of Birth	
Child:	Date of Birth	
Child:	Date of Birth	
I hereby declare that I have legal custod	ly of above named minor child(ren).	
I grant my authorization and consent for to issue consent for any transport, X-ray, anesthetic, blood transfusion, medication, or other medical, dental, or surgical diagnosis, treatment, office or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.		
treatment being required, but is given to	n in advance of any specific diagnosis or provide authority to the temporary guardian in the advice of medical, dental or emergency	
This authorization if effective commencing	ng and	
expiring		
(Parent or Legal Guardian)	(Date)	
Certificate of Acknow	wledgment of Notary Public	
STATE OF		
This document was acknowledged before on by		
Notary		
Notary Public for the State of My commission expires		