

AUTHORIZATION FOR MEDICAL TREATMENT

Name of Minor

Birthdate

In the event that I/we cannot be reached to make arrangements for emergency medical attention, I/we do hereby appoint St. Martin's Staff to act on my/our behalf in authorizing unexpected medical, dental, hospitalization and surgical care for the above named minor during our absence. This document shall be presented to the appropriate person or representative at the time care is given.

Signature

Date

Signature

Date

Insurance Company _____

ID, Group or Contract Number _____

Name of Physician: _____

Address: _____

City: _____

Phone Number: _____

Preferred Hospital _____

Address: _____

City: _____

Phone Number: _____