



I/We:

Name	Address	Telephone Numbers
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are the parent(s) or legal guardian(s) and legal custodians(s) of the following minor child/children:

Name	Medical Record No.	Date of Birth	Insurance Type and No.	Special Medical Concerns
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I/We hereby authorize:

Name	Address	Telephone Numbers
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with whom I/we am/are temporarily entrusting the care and custody of my/our minor child/children, to consent to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care to be rendered to the minor(s) under the general or specific supervision and on the advice of any physician, surgeon, or dentist licensed to practice medicine, surgery, or dentistry.

This authorization shall be effective from the date signed through \_\_\_\_\_ 20\_\_\_\_, which must not exceed six (6) months from the date signed.

Signatures:

	Date _____
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Parent/Guardian

	Date _____
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Parent/Guardian

	Date _____
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Witness