AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR MINORS AND THOSE DEEMED INCOMPETENT

In the event the undersigned parent/guardian of _____ cannot be contacted through reasonable efforts, does hereby empower and grant to:

Name:_____	address:	work :	Cell:
Name:_____	address:	work:	Cell:
Name:_____	address:	Home:	Cell:
Name:_____	address:	Home:	Cell:

the right to consent permission of any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment and/or Hospital Care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of Texas, when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful. This authorization shall be valid for the period of time commencing on _____ and ending _____. I do hereby indemnify and hold harmless the physician, hospital, and other persons who act in reliance upon this authorization.

Executed this _____._____ _____
WITNESS ***PARENT/GUARDIAN***

INFORMATION:

Parent/Guardian can be located at the following address/phone number:

Name/Phone number of Pediatrician:
Any known allergies:

Medicines child is taking:
Insurance Company:
Phone Number:
Policy #: