CONSENT FOR MEDICAL CARE FORM

The undersigned hereby authorizes: _____

to obtain medical care for: _____ _____
Name Birthdate

_____ _____
Name Birthdate

_____ _____
Name Birthdate

_____ _____
Name Birthdate

including medical and surgical treatment as ordered by the attending physician, x-ray, examinations, laboratory procedures, and hospital treatment.

_____ _____
Date Signature of Parent or Guardian