HOMEWORK SOLUTIONS

Please note: Laws and regulations vary from state to state. It is recommended that the user show this form to their physician/hospital prior to completing same, in order to ensure that this authorization will be acceptable to them.

MEDICAL TREATMENT AUTHORIZATION

Date:

To Whom It May Concern:

_____ (hereafter referred to as child care provider) is the child care provider for our child, _____. Child care provider is responsible for their care and welfare during the day, and occasionally in the evenings, on the weekends or overnight.

We hereby authorize and voluntarily consent to having child care provider arrange, direct, sign for and consent to any and all routine or emergency medical care and treatment necessary to preserve the health of our child. Personal, insurance and health care provider information is set forth below.

We acknowledge that we are responsible for all reasonable charges in connection with the care and treatment rendered and acknowledge that no guarantees have been made as to the effect of such treatment rendered.

Child Personal Information

Name:
Date of Birth:
Sex:
Eyes:
Hair:
Allergies:
Medical Conditions:
Social Security #:

Insurance Information

Employer:
Member No.:
Employee Social Security No.:
Administrator:
Group No.:
Confirmation Number:

Health Care Providers

Pediatrician: Name:
Phone Number:

Dentist: Name:
Phone Number:

_____ _____

Signature of parent Signature of Parent

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STATE OF _____, COUNTY OF _____, TO WIT:

I HEREBY CERTIFY, that on this _____ day of _____, 200___, before me, the undersigned Notary Public of the State, personally appeared _____, who acknowledged himself to be the father of _____ satisfactorily known to me (or satisfactorily proven) to be the person whose name is subscribed to the attached Medical Release of even date herewith, and acknowledged that he executed the same for the purposes therein contained.

WITNESS my hand and Notarial Seal.

_____
Notary Public

My Commission Expires:

STATE OF _____, COUNTY OF _____, TO WIT:

I HEREBY CERTIFY, that on this _____ day of _____, 200___, before me, the undersigned Notary Public of the State, personally appeared _____, who acknowledged himself to be the mother of _____ satisfactorily known to me (or satisfactorily proven) to be the person whose name is subscribed to the attached Medical Release of even date herewith, and acknowledged that he executed the same for the purposes therein contained.

WITNESS my hand and Notarial Seal.

_____
Notary Public

My Commission Expires:

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