

# AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR MINOR CHILD

WITNESS THIS AGREEMENT AND AUTHORIZATION by and between Circle Lake Ranch, Inc., hereinafter referred to as "Management" and \_\_\_\_\_, hereinafter referred to as "Parent."

Management is hereby authorized to obtain any and all medical treatment Management deems reasonably necessary for my minor child and/or children.

Parent or guardian agrees to bear any cost connected therewith and shall pay promptly upon billing by the health care provider. Management shall incur no financial liability for medical treatment obtained pursuant to this authorization.

**Name(s) of Child(ren)**

**Social Security Number**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Plan or Identification Number: \_\_\_\_\_

Primary Health Care Provider & Telephone Number:  
\_\_\_\_\_

Parent's Names and Emergency Telephone Numbers:

Mother's Name

Work Telephone

Home Telephone

Cell Phone

Father's Name

Work Telephone

Home Telephone

Cell Phone

\_\_\_\_\_  
Signature of Parent or Guardian

STATE OF ( \_\_\_\_\_ )

)SS:

COUNTY OF ( \_\_\_\_\_ )

The foregoing instrument was subscribed and sworn to before me by

\_\_\_\_\_, Parent or Guardian, on the \_\_\_\_\_ day of

\_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

My commission expires:  
\_\_\_\_\_