MEDINA FAMILY MEDICAL CLINIC
209 GRACE COVE
MEDINA TN 38355
(731) 783-0400

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody and/or authorization of the aforementioned Minor. I grant my consent _____ (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: _____.

Signed this _____day of_____, 20_____.

Child(s) Name and Date of Birth: _____

_____

_____

Parent / Legal Guardian Signature: _____

Printed Name: _____

Witness Signature: _____

Printed Name: _____