Medical Authorization Form

AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR A MINOR CHILD

 ( Required When Your Dropping Off The Child )

WITNESS THIS AGREEMENT AND AUTHORIZATION by and between ‘Post Hill Farm LLC’ 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 to bear any cost connected therewith and shall pay promptly upon billing by Health Care Provider. Management will incur no financial liability for medical treatment obtained pursuant to this agreement.

Childs Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Allergies/Diseases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Primary Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person/Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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