AUTHORIZATION TO TREAT CHILDREN IN ABSENCE OF PARENT/GUARDIAN

I hereby give permission to Glenrock Health Center to treat my child(ren) in my absence.

Children:

Name:____ Birthday:_________________

Allergies:____

Name:____ Birthday:_________________

Allergies:____

Name:____ Birthday:_________________

Allergies:____

The following person(s) has the authority to seek treatment at Glenrock Health Center for my minor children listed above:____

____

Date:_____________________

Parents Name:___________________________________ Phone:_____________________________

Signature of Parent:______________________________

This will remain effective until I notify the Glenrock Health Center to relinquish it. ________