AUTHORIZATION FOR MEDICAL CARE

I _____ hereby authorize _____
(Name of Parent or guardian) *(Name of representative)*

and/or _____ to give consent for treatment of my child
(Name of representative)

_____, _____
(Name of child) *(Date of Birth)*

This authorization is effective from _____ to _____.
(Date) *(Date)*

Child's Primary Care Physician: _____.

List of current medications and dosages: (if none, write NONE):_____

_____

Allergies: (if none, write NONE):_____

Medical History: (if none, write NONE):_____

_____

Date of last Tetanus Shot: _____

Insurance Information: (Name) _____
(Address) _____
(Phone Number)_____
(Policy Number) _____
(Insurance-Employer) _____

Guarantor Name, Birthdate, and Social Security Number:_____

_____

_____ _____
(Signature of Parent or Guardian) *(Date)*

_____
State of _____ *(Signature of Notary)*

County of _____ _____
(Date)

Commission Expires _____

The Lawrence Memorial Hospital DBA
LMH Health
325 Maine Street, Lawrence, KS 66044

Patient Label