AUTHORIZATION TO CONSENT
TO MEDICAL AND DENTAL TREATMENT
FOR A MINOR CHILD

In the event reasonable efforts to contact us at (home)_____ (work) _____, or (cell/pager) _____ have been unsuccessful, we _____ do hereby state that we are the natural parents/legal guardians having legal custody of _____ a minor, age _____, born and residing with us at _____ TN _____ do hereby unconditionally grant and authorize a teacher representative of the CHET 2016-2017 to consent to:

1. The administration of any treatment deemed necessary by Dr. _____ Phone _____ (Preferred Physician), or Dr. _____ Phone _____ _____(Preferred Dentist), or in the event the designated preferred practitioner is unavailable, by another licensed physician or dentist when the need for such treatment is immediate.

2. The hospitalization of a minor, if in the opinion of the attending physician it is deemed essential for his/her proper and adequate treatment. This authorization does NOT cover major surgery unless the medical opinions of two other licensed physicians or dentists concur to the necessity for such surgery. Information concerning the above-mentioned child's medical history, including allergies, medication being taken, and any physical impairments to which the physician should be alerted are noted on the back of this consent.

Signatures of Parents: _____ **Date** _____

_____ **Date** _____