Tri-County Head Start/Early Head Start

Authorization for Consent to Medical Treatment of Minor Child

I (we)_____ and _____ of _____, _____ county, Florida hereby states that I am (we are) the natural parent(s), legal guardian(s) having legal custody of _____, a minor, age _____ born _____ _____ who resides with me (us) at_____. I authorize the Director or any employees of **Head Start** in the city of _____ _____, County of _____, state of Florida to consent to any X-Ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general special supervision and on the advice of any physician or surgeon licensed in the state(s) of Florida when the need for such a treatment is immediate and when efforts to contact me (us) are unsuccessful.

Child's Doctor: _____
Child's Allergies: _____
Medication child is taking: _____
Choice of Specialists: _____

Dated this _____ day of _____, 20_____

_____ _____
Parent/Guardian Signature Contact Number

_____
Insurance Company

STATE OF FLORIDA COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____ 20____, by _____.

_____
Signature of Notary Public

_____
Print, Type or Stamp Name of Notary

Personally Known: _____
OR Produced Identification: _____
Type of Identification Produced: _____