

LIBRARY FORM

EMERGENCY MEDICAL AUTHORIZATION

I/We, _____ (name of parent[s]), of _____ County, Tennessee, am/are the parent(s) having legal custody of _____ (name of child[ren]), age(s) _____ . I/We hereby authorize _____ (name of appointee) and/or _____ (optional name of additional appointee) _____, adults in whose care my/our minor child(ren) has/have been entrusted, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to my/our minor child(ren) under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the continental United States, and to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care, to be rendered to my/our minor child(ren) by any dentist licensed to practice in the continental United States.

Dated this _____ day of _____, 20_____.

Witness

(name of parent)

Witness

(name of parent)