AUTHORIZATION TO PROVIDE MEDICAL CARE

Child's Name: _____
First M.I. Last

Date of Birth: _____ Social Security #:_____ Sex: _____

Address: _____
Street

_____
City State Zip

Parent's Marital Status: ○ **Married** ○ **Single** ○ **Divorced** ○ **Widowed** ○ **Guardian**

In case of an emergency and parents cannot be reached please call:

Name: _____ Phone: _____ Relationship: _____

In my absence, this is to authorize Winter Park Family Health Center for our child. If in your opinion, another physician needs to be consulted or hospitalization is indicated, we hereby authorize you to do so.

Mother, Father or Legal Guardian: _____

Witness: _____ Date: _____

The following adult persons are authorized to accompany my child and seek medical care form Winter Park Family Health Center.

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

This authorization is in effect until revoked or the date of: _____