128 E. Milltown Rd., Suite 105
Wooster, OH 44691
330.345.8060

PERMISSION FOR TREAMENT

I/We ______________________________ the ______________________________
(relationship to minor)

authorize and/or delegate ____
(name/address/relationship)

____

to act on behalf of me/us in the event I/we cannot be present, with power to obtain medical treatment, either by a physician and/or hospital for my named minor child(ren).

NAME	DATE OF BIRTH
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

This consent shall remain in effect from ______________ to ______________ (not to exceed 6-months).
(date) (date)

______________________________ Signature	____________________ Date
______________________________ Printed Name	____________________ Date
______________________________ Witness	____________________ Date