

Great Beginnings Early Childhood Center
795 1600 Rd. Delta, CO 81416
970-874-8399

MEDICAL AUTHORIZATION

FOR _____

THE UNDERSIGNED, WHO ARE THE PARENTS OR GUARDIANS HAVING LEGAL CUSTODY OF THE ABOVE NAMED MINOR, HEREBY AUTHORIZE THE ABOVE-NAMED CENTER, INTO WHOSE CARE THE ABOVE-NAMED MINOR HAS BEEN ENTRUSTED, TO CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT, AND HOSPITAL CARE TO BE RENDERED TO SAID MINOR UNDER THE GENERAL OR SPECIAL SUPERVISION AND UPON THE ADVICE OF A PHYSICIAN AND SURGEON LICENSED UNDER THE PROVISIONS OF THE MEDICAL PRACTICE ACT, OR TO CONSENT TO AN X-RAY EXAMINATION, ANESTHETIC, DENTAL OR SURGICAL DIAGNOSIS OR TREATMENT, AND HOSPITAL CARE TO BE RENDERED TO SAID MINOR BY A DENTIST LICENSED UNDER THE PROVISIONS OF THE DENTAL PRACTICE ACT. THE UNDERSIGNED FURTHER AUTHORIZE THE ABOVE-NAMED CENTER TO HAVE THE ABOVE-NAMED MINOR RELEASED INTO THE CUSTODY OF ITS REPRESENTATIVE, SHOULD HOSPITAL CARE NO LONGER BE REQUIRED.

THIS FORM IS TO BE USED ONLY IN AN EXTREME EMERGENCY, WHEN SAID PARENTS OR GUARDIANS CANNOT BE OR ARE UNAVAILABLE TO BE CONTACTED.

Signed _____ Date _____

Signed _____ Date _____
