

I (We) of _____
(Street Address) (City, State & Zip) (County)

Ohio, do hereby state that I am (we are) the natural parent(s) or legal guardian of
_____, age _____, birth date _____
(Name of Child)

I (We) authorize _____ to give
(Name of Person Taking Care of Child)
consent for medical care of said child. I (We) authorize Doctor _____ to provide all
necessary medical care and treatment for the child which the medical provider determines necessary for the
health and well-being of my (our) child.

This authorization is for the following period: _____ to _____

Parent/Guardian Signature _____ Parent/Guardian Signature _____

Address _____ Address _____

_____ _____
Date _____ Date _____

Witnessed by:

Witness Signature _____ Print Name _____

Address _____

Date _____

OTHER INFORMATION

Allergies _____

Date of Last Tetanus _____

This authorization is *not* for immunizations