Authorization MEDICAL TREATMENT OF MINORS

This document shall be presented to a physician, dentist, or ar unexpected medical, dental, surgical care or f PARENT/GUARDIAN SIGNATURE FAMILY PP 	g the period of my/our absence, from: MONTH: <u>December</u> DAY: <u>31</u> YEAR: <u>2024</u> ppropriate hospital representative at such time as hospitalization may be required. HYSICIANS Phone icy# I AUTHORIZATION in hedication from home following the direction on the b)
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