AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned _____ and _____, who reside at _____, _____ Ohio, and who are the parents of _____ age _____, and _____, age _____, hereby authorize _____, an adult person to whom the care of said minor children has be entrusted while the undersigned are temporarily outside the State of Ohio and who resides at _____, _____, Ohio _____, Telephone (_____) _____, to consent to any emergency medical, dental or surgical diagnosis, procedure or treatment and hospital care to be rendered to either or all of said minor children under the general or special advice and supervision of a physician, surgeon, or dentist licensed to practice medicine or dentistry in the State of Ohio. This authorization does not cover major surgery unless the written opinions of at least two licensed physicians or dentists who concur in the need for such surgery are obtained prior to the performance of such surgery are obtained prior to the performance of such surgery.

If for any reason, said _____, is unable to provide such consent, or if reasonable attempts to contact him or her for such consent are unsuccessful, the undersigned hereby authorizes _____, an adult who resides at _____, _____, Ohio _____, Telephone (_____) _____, to give any such consent as may be necessary.

Signed at _____, Ohio this ____ day of _____, 20_____.

Signed in the presence of:

_____ _____
(printed name of parent)_____

_____ _____
(printed name of parent)_____