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 for a trip 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. 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)________________________