AUTHORIZATION TO TREAT MINOR

(I)(We), the undersigned, parent(s) of _____, a minor, do hereby authorize _____as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon who is licensed to practice in the state of Montana, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital.

Comments: (Reason for parent's unavailability to consent, limitations on treatment consented to, etc)

_____

_____

_____

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such medical or surgical diagnosis or treatment or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

This authorization is effective _____, 200__, and shall remain effective until _____, 200__, unless sooner revoked in writing delivered to said agent(s).

Date: _____

Parent _____

Parent _____

Legal Guardian _____

Witness _____ Date _____