HOMEWORK SOLUTIONS
homeworksolutions.com

Medical Treatment Authorization

2 Pidgeon Hill Dr.
Suite 300
Sterling, Virginia 20165

Phone (703) 404-8151
Toll Free (800) 626-4829
Fax (703) 404-8155

Laws and regulations vary from state to state.
It is recommended that the user show this form to their physician/hospital prior to completing same to ensure that this authorization will be acceptable to them.

To Whom It May Concern:

_____ (hereafter referred to as child care provider) is the child care provider for our child, _____.

Child care provider is responsible for their care and welfare during the day, and occasionally in the evenings, on the weekends or overnight.

We hereby authorize and voluntarily consent to having child care provider arrange, direct, sign for and consent to any and all routine or emergency medical care and treatment necessary to preserve the health of our child. Personal, insurance and health care provider information is set forth below.

We acknowledge that we are responsible for all reasonable charges in connection with the care and treatment rendered and acknowledge that no guarantees have been made as to the effect of such treatment rendered.

Child Personal Information

Name

Child SSN

Date of Birth

Sex

Hair

Eyes

Allergies

Medical Conditions

Insurance Information

Name

Employer

Employee SSN

Member Number

Administrator

Group Number

Confirmation Number

Healthcare Providers

Pediatrician

Phone Number

Dentist

Phone Number

Date

Parent Signature

Parent Signature

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STATE OF _____ COUNTY OF _____ , TO WIT

I HEREBY CERTIFY, that on this __ day of , 20 __ , before me, the undersigned Notary Public of the State, personally appeared _____ who acknowledged himself to be the father of _____ satisfactorily known to me (or satisfactorily proven) to be the person whose name is subscribed to the attached Medical Release of even date herewith, and acknowledged that he executed the same for the purposes therein contained.

WITNESS My Hand and Notarial Seal

My Commission Expires

_____

Notary Public

_____

STATE OF _____ COUNTY OF _____ , TO WIT

I HEREBY CERTIFY, that on this __ day of , 20 __ , before me, the undersigned Notary Public of the State, personally appeared _____ who acknowledged herself to be the mother of _____ satisfactorily known to me (or satisfactorily proven) to be the person whose name is subscribed to the attached Medical Release of even date herewith, and acknowledged that he executed the same for the purposes therein contained.

WITNESS My Hand and Notarial Seal

My Commission Expires

_____

Notary Public

_____