

**3519 Easter Stanley Court ~ Tallahassee, Florida 32308**

**P: (850) 921-KIDS(5437) ~ F: (850) 921-4734**

**Emergency Medical Authorization**

I (We) and

Parent/Guardian Parent/Guardian

of

Street City State Zip Code Country

do herby state that I am (we are) the parent(s) or legal guardian(s) having legal custody of

, born

Child’s Name Birth Date

who resides with me (us) at the address listed above, do authorize the Director or any employee of the Dick Howser Center to consent to any x-ray examination, anesthetic, medical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the State of Florida when such treatment is immediate, and when efforts to contact me (us) are unsuccessful.

Hospital Preference: 🔾 Tallahassee Memorial Hospital 🔾 Capital Regional Medical Center

🔾 Other:

Child’s Doctor: Phone Number:

Parent’s Doctor: Phone Number:

Parent/Guardian Signature: Date:

Parent/Guardian Signature: Date:

The forgoing instrument was acknowledged before me this day of , 20 .

Print, Type of Stamp Name of Notary

Personally Known

Or Produced Identification

Type of ID and ID#