MEDICAL TREATMENT AUTHORIZATION FOR A MINOR

We, ____

hereby grant Kahea Hart and Claudia Cox, of 58-118 Kaunala St., Haleiwa, Hawaii 96712, the authority to obtain medical treatment for the following child(ren):

Name of Child:

Birthdate:

The above care provider(s) are authorized to:

- obtain medical treatment and procedures for the child(ren) as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate health care providers.

- obtain routine medical treatment from appropriate health care providers if symptoms of illness occur (e.g., fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.).

This grant of temporary authority shall begin on ____/_____/______, and shall remain effective through ____/_____/______.

The care provider(s) may provide the physician and other health care providers with the following health insurance information:

Insurance Company:

____

Policy Number:

____

Name of Policy Holder:

____

Parent Address:

Preferred Phone Number:

Alternate Phone Number:

STATE OF ________________________ss: COUNTY OF _________________, ss:

On this _____ day of ____________________, _____, before me personally appeared ________________________________, to me known to be the person described in and who executed the foregoing Consent for Medical Treatment of a Minor, and, being first duly sworn on oath according to law, deposes and says that he/she has read the foregoing Consent for Medical Treatment of a Minor subscribed by him/her, and that the matters stated herein are true to the best of his/her information, knowledge and belief.

____

Notary Public

____

Title (and Rank)

My commission expires ______________