

# AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR MINOR CHILD

WITNESS THIS AGREEMENT AND AUTHORIZATION by and between Spruce Meadow Farm, hereinafter referred to as "Management," and \_\_\_\_\_, hereinafter referred to as "Parent."

Management is hereby authorized to obtain any and all medical treatment Management deems reasonably necessary for my minor child and/or children.

Parent or guardian agrees to bear any cost connected therewith and shall pay promptly upon billing by the health care provider. Management shall incur no financial liability for medical treatment obtained pursuant to this authorization.

Name(s) of child(ren)

Social Security No.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Plan or Identification No. \_\_\_\_\_

Primary Healthcare Provider \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian