Authorization to Treat

Patient/Guardian Name: _____

Child/Children's Name: _____ AGE:_____

Child/Children's Name: _____ AGE:_____

Child/Children's Name: _____ AGE:_____

Phone Number HOME:_____

CELL:_____

Home Address: _____

Medical History:_____

_____

_____

Current Medications: _____

_____

Drug/Food Allergies: _____

In case of injury or illness, I hereby authorize Discovery Cove Health Services and it's designated doctor or hospital to provide the necessary medical attention, examination, treatment, and care.

Signature of Parent or Guardian: _____ Date:_____