ASHFORD
CHILD ENRICHMENT CENTER
love bless teach

AUTHORIZATION OF CONSENT
FOR TREATMENT OF MINOR

I the undersigned, parent/guardian of_____, a minor, do hereby authorize the
Print full name of minor
bearer of this form as agent for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital.

It is understood that this authorization is given in advance of specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of my aforesaid agent to give specific consent to any and all such diagnosis, treatment, or hospital care which aforementioned physician/surgeon in the exercise of his/her best judgment may deem advisable.

I hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to my above-named agent upon the completion of treatment. This authorization shall be valid for as long as the child is enrolled at Ashford Child Enrichment Center.

_____
Parent or Legal Guardian

Date: _____

STATE OF TEXAS

COUNTY OF _____

This instrument was acknowledged before me on the _____ day of _____ , 20 _____ by

_____
Notary Public, State of Texas

My commission expires: _____

_____
Printed or stamped name of Notary