____, ____________________________________

(LAST NAME) (minor child) (FIRST NAME)

CONSENT TO MEDICAL TREATMENT

I, ________________________________, the (parent) (guardian) of __________________________________, a minor child whose birth date was ______________________________,__________ and who is the child of ____ and ____ hereby authorizes any duty authorized doctor, hospital or other medical facility ro treat said minor on or after ______________________________,__________ for the purpose of attempting to treat or relieve any injuries received by said minor while he/she was a participant or observer at ____.

I authorized any licensed physician to perform any procedure which he deems advisable in attempting to treat or relieve any injuries or any related unhealthy condition of said minor that he may encounter during any necessary operation.

I consent to the administration of anesthesia as deemed advisable by any licensed physician.

I realize and appreciate that there is a possibility of complications and unforeseen circumstances in any medical treatment and I assume any such risk on the behalf of myself and said minor I acknowledge that no warranty is being made as to the results of any treatment.

______________________________________ ______________________________________

NAME RELATIONSHIP TO MINOR

STATE OF ____________________§

COUNTY OF __________________§

BEFORE ME, a Notary Public in and for said County and State,personally appeared ______________________________________ who acknowledged that he has read the above and foregoing instruments and that the execution was his voluntary act and deed and that all statements therein are true and correct.

Witness my hand and seal this ____________________day of_________________________, 20_________.

____

Notary Public in and for

_________________________ County, _________

My Commission Expires: _____________________