AUTHORIZATION FOR EMERGENCY TREATMENT OF MINOR CHILD

This document authorizes emergency medical treatment of the minor child (under 18 years of age) in the absence of parent(s) or legal guardian(s). The original completed and signed copy of this form shall be presented by (or on behalf of) the minor.

<table>
<tr><td>THE MINOR</td><td>NAME (First, Last)</td><td>BIRTHDATE</td><td></td></tr>
<tr><td rowspan="3">PARENT/GUARDIAN</td><td colspan="3">I / We the parent(s) or legal guardian(s) of the above named minor authorize emergency medical treatment by affiliated physician(s) and staff personnel and the below hospital facility throughout the specified dates and assume responsibility for all costs not covered by insurance policy.</td></tr>
<tr><td>PARENT(S) OR LEGAL GUARDIAN(S)</td><td>HOME PHONE</td><td>CELL PHONE</td></tr>
<tr><td>ADDRESS</td><td colspan="2">SIGNATURE</td></tr>
<tr><td rowspan="6">MINOR'S HOSPITALIZATION COVERAGE</td><td>HOSPITAL FACILITY:
Name of Hospital
or Closest
_____</td><td>INCLUSIVE DATES OF AUTHORIZATION (if dated)</td><td>FROM _____
TO _____</td></tr>
<tr><td colspan="2">NAME OF INSURANCE COMPANY</td><td>POLICY NUMBER</td></tr>
<tr><td colspan="3">ADDRESS OF INSURANCE COMPANY</td></tr>
<tr><td colspan="2">NAME OF INSURED</td><td>RELATIONSHIP TO MINOR</td></tr>
<tr><td colspan="2">ADDRESS</td><td>LAST FOUR OF SS NUMBER</td></tr>
<tr><td></td><td colspan="3"></td></tr>
<tr><td rowspan="3">MINOR'S MEDICAL INFORMATION</td><td colspan="3">ALLERGIES OR SPECIAL CONDITIONS

EMERGENCY TREATMENT</td></tr>
<tr><td colspan="3">NAME OF PHYSICIAN</td></tr>
<tr><td colspan="2">ADDRESS</td><td>TELEPHONE</td></tr>
</table>

PLEASE SIGN IN THE PRESENCE OF A STAFF MEMBER AT THE TIME OF REGISTRATION

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____ _____

WITNESS DATE