AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF MINOR CHILD

1. I, _____ (parent/guardian name) of _____ (address) make oath and say that I am the lawful guardian of the child listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

   _____ (minor's name), _____ (sex), age ____, born _____ at _____(city), _____(state) and residing at _____.
   Health Insurance: _____
   ID #_____ Group #_____
   Blood Type: ___
   Rh Factor: _____

2. I hereby authorize and appoint _____ as my agent. My agent may consent to my child's surgical, dental, developmental, mental health and/or medical examination or treatment. Such treatment may include but is not limited to the following:
   1. transportation by ambulance
   2. examination
   3. x-rays
   4. diagnoses
   5. hospitalization
   6. anesthesia
   7. surgery
   8. medication
   9. transfusion of blood or blood products

   My agent may have access to any and all records, including, but not limited to, insurance records regarding any such services.

3. Our family doctor may be contacted at this address:
   Aspen Medical Care, PC
   101 Founders Place, Suite 109
   Aspen, Colorado 81611
   Telephone: 970-920-0104
   Fax: 970-920-0124

4. The purpose of this instrument is to give my agent the power and authority to consent to medical treatment for my child and this power and authority will be effective as of the _____ day of _____, 20___, and will remain effective until the _____ day of _____, 20___.

5. I give this consent freely and knowingly in order to provide for the child and not as a result of pressure, threats or payments by any person or agency.

IN WITNESS WHEREOF I hereunto sign my name at _____ (city), _____ (state) this ____ day of _____, 20___.

_____
Parent/Guardian Signature

_____ witness

_____ witness

_____ print name

_____ print name