Rosemarie Tweed, D.O.

Jesse Tweed, M.D.

Authorization for Medical Treatment of Minor

Child: _____ Date of Birth _____

Child:_____ Date of Birth _____

Child:_____ Date of Birth _____

I hereby declare that I have legal custody of above named minor child(ren). I grant my authorization and consent for _____ to issue consent for any transport, X-ray, anesthetic, blood transfusion, medication, or other medical, dental, or surgical diagnosis, treatment, office or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this consent is given in advance of any specific diagnosis or treatment. I grant authority to the person named above to exercise their best judgment upon the advice of medical, dental or emergency personnel.

This authorization if effective commencing _____ and

expiring _____.

Parent/Legal Guardian Name _____

_____ _____

(Parent or Legal Guardian Signature) (Date)