

## EMERGENCY MEDICAL AUTHORIZATION

I/We, \_\_\_\_\_ (names of parent[s]), of \_\_\_\_\_ County, Tennessee, am/are the parent(s) having legal custody of \_\_\_\_\_ (name of child and age). I/We hereby authorize \_\_\_\_\_ (name of appointee) and/or \_\_\_\_\_ (optional name of additional appointee), adults in whose care my/our minor child has been entrusted, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to my/our minor child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the continental United States, and to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care, to be rendered to my/our minor child by any dentist licensed to practice in the continental United States.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
First Witness

\_\_\_\_\_  
Parent

Printed Name: \_\_\_\_\_

\_\_\_\_\_  
Second Witness

\_\_\_\_\_  
Parent

Printed Name: \_\_\_\_\_

