AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR MINOR CHILD

WITNESS THIS AGREEMENT AND AUTHORIZATION by and between FARM NAME, hereinafter referred to as "Management," and _____, hereinafter referred to as "Parent."

Management is hereby authorized to obtain any and all medical treatment Management deems reasonably necessary for my minor child and/or children.

Parent or guardian agrees to bear any cost connected therewith and shall pay promptly upon billing by the health care provider. Management shall incur no financial liability for medical treatment obtained pursuant to this authorization.

Name(s) of child(ren) Social Security No.

_____ _____

_____ _____

_____ _____

Health Insurance Carrier: _____

Plan or Identification No. _____

Primary Healthcare Provider _____

_____
Signature of Parent or Guardian

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ (date), by _____ (name), who is personally known to me or who has produced _____ (type of identification) as identification.

_____
Notary Public

My Commission Expires: _____ Printed Name:_____

Commission #_____