PERMISSION TO AUTHORIZE MEDICAL CARE

To Whom It May Concern:

I, the undersigned parent, or legal guardian, does hereby give the following individual(s):

Name:	Relationship to Child:
_____	_____
_____	_____
_____	_____
_____	_____

permission to authorize the Lawton Community Health Center (Doctor/Nurse/PA/ARNP, etc.) to provide routine (normal) or emergency medical care as they deem necessary in the best interest and health of my child:

Child's Name: _____

DOB:_____/_____/_____ Child's Social Security #:_____-_____-_____

This authorization shall remain in effect until revoked by me.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Verification Signature Date

5/14/2012