

TELLURIDE MEDICAL CENTER'S AUTHORIZATION FOR
EMERGENCY TREATMENT OF MINORS

I, _____, authorize the Telluride Medical
(print parent/guardian name)

Center, it's agents, employees or any member of it's medical staff, to render
emergency medical care to my child(ren), _____,
(print child's name)
as is considered in their medical judgment to be necessary or beneficial.

I am aware that the practice of medicine is not an exact science and I
acknowledge that no guarantees have been made to me as to the result of
treatments or examinations at the Telluride Medical Center.

DRUG ALLERGIES: _____

CURRENTLY TAKING THESE
MEDICATIONS: _____

PAST MEDICAL COMPLICATIONS:

CURRENT MEDICAL
COMPLICATIONS: _____

X _____ DATE _____
(Signature of parent/guardian)

Physician's Name: _____ City's Name _____

Parent's Names _____

Physical Address _____

Phone #: cell _____ cell _____
work _____ work _____