_____ , _____

(LAST NAME) (minor child) (FIRST NAME)

CONSENT TO MEDICAL TREATMENT

I, _____, the (parent) (guardian) of_____, a minor child whose birth date was_____, _____ and who is the child of _____ _____ and _____ hereby authorizes any duly authorized doctor, hospital or other medical facility to treat said minor on or after _____, _____ for the purpose of attempting to treat or relieve any injuries received by said minor while he was a participant or observer at _____.

I authorized any licensed physician to perform any procedure which he deems advisable in attempting to treat or relieve any injuries or any related unhealthy condition of said minor that he may encounter during any necessary operation.

I consent to the administration of anesthesia as deemed advisable by any licensed physician.

I realize and appreciate that there is a possibility of complications and unforeseen circumstances in any medical treatment and I assume any such risk on the behalf of myself and said minor I acknowledge that no warranty is being made as to the results of any treatment.

_____ _____

NAME RELATIONSHIP TO MINOR

STATE OF _____ §

COUNTY OF _____ §

BEFORE ME, a Notary Public in and for said County and State, personally appeared _____ _____ who acknowledged that he has read the above and foregoing instruments and that the execution of both was his voluntary act and deed and that all statements therein are true and correct.

Witness my hand and seal this _____day of _____, _____ .

_____

Notary Public in and for

_____County, _____

My Commission Expires: _____