



**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 TENNESSEE

COUNTY OF _____

On this _____ day of _____, 20 _____, before me personally appeared _____, to me known to be the person (or persons) described in and who executed the foregoing instrument, and acknowledged that such person (or persons) executed the same as such person (or person's) free act and deed.

Notary Public

Printed Name: _____

Commission Expires: