

**AUTHORIZATION CONSENTING TO MEDICAL TREATMENT
FOR MINOR CHILD**

I, _____, the parent of _____,
a minor child who was born on _____ and resides at
_____ in the County

of Nassau in the State of New York, authorize an adult at Our Lady of Victory's Child Care to seek emergency treatment for my child. Such treatment includes but is not limited to examination, X-rays, laboratory tests, medical and surgical treatment, use of medication, anesthetics, sutures, and admission for hospital care should this be necessary, when efforts to contact me are unsuccessful. It is understood that such care will be given upon the advice of a duly licensed physician or surgeon.

My family doctor is _____

Phone Number _____ I authorize that you
may call him/her in case of an emergency. Any physician acting in his/her place should be advised that my child
has the following allergies _____

Sworn to before me this _____ day of _____ 20_____

NOTARY PUBLIC

SIGNATURE OF PARENT/GUARDIAN