

# Smolak Farms

315 South Bradford Street, North Andover, MA 01845

## AUTHORIZATION AND CONSENT TO MEDICAL TREATMENT

TO ANY PHYSICIAN, SURGEON, NURSE, HOSPITAL OR ALL OTHER MEDICAL PERSONNEL OR INSTITUTION THAT IS FURNISHING MEDICAL CARE, MEDICAL TREATMENT OR OTHER MEDICAL OR RELATED SERVICES TO \_\_\_\_\_ (child's name) OR CONSIDERING DOING SO:

I / WE \_\_\_\_\_ (natural parents / legal guardian / legal conservator / trustee / individual client) GIVE SMOLAK FARMS AND / OR THEIR REPRESENTATIVE PERMISSION TO MAKE DECISIONS AND TO GIVE YOU AUTHORIZATION REGARDING \_\_\_\_\_ (child's name) PHYSICAL OR MEDICAL CARE AND TREATMENT WHICH HE OR THEY IN THEIR SOLE DISCRETION THINK NECESSARY, TO ENSURE EMERGENCY TREATMENT AND TO CONSENT TO THE ADMINISTRATION OF ANESTHETICS AND TO THE PERFORMANCE OF ANY EMERGENCY OPERATION UPON \_\_\_\_\_ (child's name) AT ANY LICENSED MEDICAL FACILITY, AND I / WE REQUEST THAT YOU ABIDE BY ALL SUCH DECISIONS AND INSTRUMENTS, FURTHER, ANY PERSON, INCLUDING WITHOUT LIMITATION, SMOLAK FARMS AND / OR THEIR REPRESENTATIVE, MAKING DECISIONS OR EXERCISING AUTHORITY HEREUNDER SHALL HAVE NO LIABILITY EXCEPT FOR GROSS NEGLIGENCE. I / WE WISH TO BE NOTIFIED AS SOON AS REASONABLY POSSIBLE OF ANY SUCH TREATMENT. \_\_\_\_\_ (child's name) IS COVERED BY THE FOLLOWING INSURANCE:

**NAME OF INSURANCE COMPANY** \_\_\_\_\_  
**POLICY NUMBER** \_\_\_\_\_  
**DOCTOR'S NAME** \_\_\_\_\_ **DOCTOR'S #** \_\_\_\_\_

THIS AUTHORIZATION AND CONSENT SHALL BE EFFECTIVE FOR THE FOLLOWING PERIOD \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **THROUGH** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, UNLESS TERMINATED BY CONTRARY WRITTEN INSTRUCTIONS. I HEREBY WAIVE ANY CLAIM I / WE MIGHT OTHERWISE HAVE AGAINST YOU FOR ABIDING BY THIS AUTHORIZATION AND CONSENT AFTER IT HAS BEEN TERMINATED IF YOU ACTED WITHOUT PERSONAL KNOWLEDGE OF SUCH TERMINATION.

### HEALTH INFORMATION

TODAY'S DATE \_\_\_\_\_

ALLERGIES \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

- **EPI-PEN** I AM GIVING MY CHILD'S EPI-PEN TO THE SMOLAK FARMS NATURE AND CRAFT STAFF SO THAT, IN THE EVENT MY CHILD EXPERIENCES AN ALLERGIC REACTION, THEY MAY ADMINISTER A SHOT FROM THE EPI-PEN
- **SIGNATURE** \_\_\_\_\_

PARENT / GUARDIAN NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

TOWN / STATE / ZIP CODE \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_