AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Except in a true emergency, medical, dental, health, or hospital care may be ordinarily rendered to a child only with the permission of a parent/guardian. It is the law. In case of emergency when you cannot be reached, this completed form will allow the appointed persons noted below to authorize treatment on your behalf.
PLEASE NOTE: Every effort will be made to reach you prior to making any decisions about emergency care for your child(ren).

NAMES OF MINORS	BIRTHDATES	IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

I/We, being the parent(s) or legal guardian(s) or the above named minor(s), do hereby appoint:

Andrea Wandersee	Open Hand Theater, 3948 Erie Blvd. E. Syracuse, NY 13214	315-414-9382 (cell) 315-476-0466 (work)
Peter Fekete	Open Hand Theater, 3948 Erie Blvd. E. Syracuse, NY 13214	315-530-8785 (cell) 315-476-0466 (work)
Caitlin Friedberg	Open Hand Theater, 3948 Erie Blvd. E. Syracuse, NY 13214	315-481-3351 (cell) 315-476-0466 (work)

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence from:

check one	Month	Day	Year	through	Month	Day	Year
	January	1	2018		December	31	2018

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent/Guardian	**Parent/Guardian**
Signature:	Signature:
Address: Phone (H): Phone (W):	Address: Phone (H): Phone (W):
Date:	Date:

HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR(S):

Insurance Company or Government Program	I.D. or Contract Number

FAMILY PHYSICIANS:

Name and Phone Number	Name and Phone Number