AUTHORIZATION TO OBTAIN MEDICAL TREATMENT

FOR MINOR CHILD

WITNESS THIS AGREEMENT AND AUTHORIZATION by and between Splendor Farms, LLC, hereinafter referred to as “the farm.” and

____, hereinafter referred to as “Parent.”

The Farm is hereby authorized to obtain any and all medical treatment The Farm may deem reasonable 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. The farm shall incur no financial liability for medical treatment obtained pursuant to this authorization.

NAMES OF CHILREN SOCIAL SECURITY NUMBER

Health Insurance Carrier:____

Plan or Identification Number:____

Primary Health care Provider & Telephone Number:_______________________________

Parents Names and Emergency Telephone Numbers:

Name(s) Work # Cell # Home #

Emergency Contact – Name and Telephone Number

SIGNATURE OF PARENT:____

STATE OF LOUISIANA

PARISH OF __________________________

NOTARY PUBLIC/COMMISSION EXPIRES:___________________