# AUTHORIZATION FOR MEDICAL TREATMENT

I, __________________________, certify that I am **[18 years old or older and] [guardian of __________________ and]** (circle one) competent to execute this Authorization for Medical Treatment. I hereby authorize Independence Farm LLC and its employees and agents to consent **[on my behalf] [on behalf of ________________]** to the delivery of medical and dental services, including but not limited to emergency care, surgery or other hospital care under the supervision of a licensed physician or dentist.

**Signature:** ______________________________
**Name (printed):** ______________________________
**Name(printed) of minor:** ______________________________
**Date:** ______________________________
**Witness Signature:** ______________________________
**Witness Name (printed):** ______________________________



Initials _______

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