AUTHORIZE TO CONSENT TO MEDICAL TREATMENT OF CHILDREN

1. We, ____________________ of ________________________ and ____________________ of ________________________ make oath and say that we are the lawful guardians of the children listed below and there are no court orders now in effect that would prohibit us from conferring the power to consent upon another person.

Information of First Child

____________________, male, born May 2, 2025 at ________________________ and residing at ____

Health insurance information:

____

Medications currently used:

____

Illnesses, medical conditions, and/or allergies:

____

Information of Second Child

____________________, male, born May 2, 2025 at ________________________ and residing at ____

Health insurance information:

____

Medications currently used:

____

Illnesses, medical conditions, and/or allergies:

____

2. We hereby authorize and appoint 3BFIT Body Beauty Brain Meditation & Yoga of 1515 Lewis St, Unit 145, Indianapolis, IN 46202 as our agent (our "Agent"). Unless otherwise provided in this authorization, our Agent may consent to emergency and routine medical treatment for our children, including dental treatment, anaesthesia, and blood transfusion.

3. Our Agent may have access to any and all records, including, but not limited to, insurance records regarding any medical services or treatment provided.

4. Our family doctor may be contacted at:

   Name: ___________________________________
   Address: ______________________________
   Phone Number: ________________________
   Email: _________________________________

5. The purpose of this instrument is to give 3BFIT Body Beauty Brain Meditation & Yoga the power and authority to consent to medical treatment for our children. This power and authority will be effective as of the 2nd day of May, 2025.

6. We give this consent freely and knowingly in order to provide for the children and not as a result of coercion, duress or payments by any person or agency.

7. This consent will remain in effect until it is revoked by notifying our children's medical, mental health care and insurance providers, in writing, and the Agent named above that we wish to revoke it.

8. Any questions or concerns regarding this authorization may be directed to us at:

   Name: _____________________
   Address: __________________________
   Phone Number: _____________________
   Secondary Phone: _____________________
   Email: _____________________

   Name: _____________________
   Address: __________________________
   Phone number: _____________________
   Secondary Phone: _____________________
   Email: _____________________

9. If the children become ill or injured, the Agent will first try to contact the parents/guardians. If the parents/guardians cannot be reached, the Agent should contact the following emergency contact:

Name: ____________________
Phone Number: ____________________
Secondary Phone: ____________________

IN WITNESS WHEREOF, we hereunto sign our names at ____________________, Indiana this ________ day of ________________, ________.

_________________________________ _________________________________
____________________ ____________________

_________________________________ _________________________________
Witness Witness

_________________________________ _________________________________
Print Name Print Name

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