MEDICAL TREATMENT AUTHORIZATION FOR A MINOR

We, (name of parent's), hereby grant (guardian), of (address, city state, zip) the authority to obtain medical treatment for the following child
(ren):

The above care provider(s) are authorized to:

- obtain medical treatment and procedures for the child(ren) as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate health care providers.

- obtain routine medical treatment from appropriate health care providers if symptoms of illness occur (e.g., fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.).

This grant of temporary authority shall begin on date, and shall remain effective until terminated by the undersigned.

In case of an emergency, the care provider(s) should first try to contact the parent(s). If the parent (s) cannot be reached, the care provider should then contact the following person(s) in the order listed below:

Name of Child: _____
Birthdate: _____

Name: Guardian _____
Relationship to Child: _____
Address: _____
_____

Place of Employment: _____
Preferred Phone Number: _____
Alternate Phone Number: _____
Name: _____

If the child(ren) become ill, the care provider(s) will first try to contact the parent(s). If the parent (s) cannot be reached, the care provider should contact the following physician:

The care provider(s) may provide the physician and other health care providers with the following

health insurance information:

Dated: _____

_____
(your name)

_____
(spouse)

Relationship to Child: _____
Address: _____
_____
Place of Employment: _____
Preferred Phone Number: _____
Alternate Phone Number: _____
Name of Physician: _____
Address: _____
_____
Phone Number: _____
Insurance Company: _____
Policy Number: _____
Name of Policy Holder: _____
Parent Address: _____
_____
Preferred Phone Number: _____
Alternate Phone Number: _____