MEDICAL TREATMENT AUTHORIZATION FOR A MINOR FORM

I, _____, Parent/Legal Guardian, hereby grant _____, of _____, the authority to obtain medical treatment for the following child)ren:

The above care provider(s) has my authorization 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 _____and shall remain effective until terminated by the undersigned.

In case of emergency, the care provider(s) shall first attempt to contact the parent(s) or legal guardian. If the parent/guardian cannot be reached, the care provider should then contact the following person(s) listed below:

Name: _____
Relationship to Minor: _____
Address: (Street) _____
(City/State/Zip Code) _____
Preferred Phone Number: (____) _____
Alternate Phone Number: (____) _____

If the Minor becomes ill, the care provider(s) will first attempt to contact the parent/legal guardian. If the parent/legal guardian cannot be reached, the care provider should contact the following physician:

Name: _____
Office Address: (Street)_____
(City/State/Zip Code) _____
Office Phone Number: (____) _____
If the Minor(s) need hospitalization, the preferred hospital choice is: _____.

Medial Insurance Carrier: _____

_____ _____
(Signature of Parent/Legal Guardian) (Date)