Authorization for Medical Treatment

I(We) _____
Parent(s)/Guardian(s) Names

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____
Daytime Phone # Cell Phone # Evening #

Do hereby state that I am (we are) the parent(s)/Guardian(s) having legal custody of:

_____ is a minor child, born on _____.
Childs's Name Child's Date of Birth

If I/we cannot be reached I/we authorize the following person to authorize medical services for my(our)

child Agency Nurse an adult who works at _____
School Representative School Name and Address

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

This authorization will expire on : _____

Signed: _____ Date: _____

Medical Information

Child's allergies, if any: (medication, insects, food, etc.) _____

Usual Treatment: _____

Existing Medical problems or conditions, if any: _____

Medications your child is taking (list schedule on reverse):_____

Child's Doctor: _____ Phone Number: _____

_____ _____ _____
Insurance Company Group Number ID Number

Date of last Tetanus shot: _____

In case of emergency, a parent/guardian we can reach:

Name: _____ Relationship to child: _____

Daytime phone number: _____ Evening phone number: _____

Name: _____ Relationship to child: _____

Daytime phone number: _____ Relationship to child: _____