Authorization for Emergency Treatment of Minors

Children's Names _____ Date of Birth _____

_____ _____

_____ _____

_____ _____

I, being the parent or legal guardian of the above named minor, do hereby appoint:

Name _____ Phone _____

Relationship to minor(s) _____

To act on my behalf in authorizing emergency medical, dental or surgical care and hospitalization in my absence for above named minor(s).

Parent/Guardian Name _____

Street Address _____

State _____ Zip _____ Phone _____

Insurance Company Name _____ ID # _____

Or attach a copy of card with this form

Family Physician _____ Phone _____

Drug Allergies:

Child's Name _____ Medication Name _____

Child's Name _____ Medication Name _____

Child's Name _____ Medication Name _____

Child's Name _____ Medication Name _____

Last Tetanus Toxoid Booster:

Child's Name _____ Date _____

Child's Name _____ Date _____

Child's Name _____ Date _____

Child's Name _____ Date _____

Other pertinent medical data _____

_____

This authorization is only valid for the following period of time

From _____ To _____

_____ _____

Signature of Parent/Guardian Notary Public

Signed and sworn before me on _____, 20__. (seal)