

Medical Treatment Authorization Form

NAME OF MINOR

BIRTH DATE

ALLERGIES, SPECIAL CONDITIONS OR MEDICATIONS

I/We being the parental or legal guardian(s) of the above named minor, do hereby appoint:

Name: _____ Address: _____ Home Phone: _____

Cell Phone: _____

Name: _____ Address: _____ Home Phone: _____

Cell Phone: _____

To act on my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor during the period of my/our absence, from:

Month _____ Day _____ Year _____ THROUGH Month _____ Day _____ Year _____

This document shall be presented to a physician, dentist or appropriate hospital representative at such time that unexpected medical, dental, surgical care or hospitalization may be required.

FAMILY PHYSICIAN / PEDIATRICIAN:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Parent/Guardian Signature

Address

City/State/Zip Code

Date

Notary Public Witness:

State of: _____ County of: _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

My Commission Expires: _____

Signature

}
} }
Notary Seal