

Authorization for Minor's Medical Treatment

Child

Name: _____

Birthdate: _____ Age: _____ Grade in school: _____

Doctor (or HMO): _____

Address: _____

Phone: _____

Medical insurer/health plan: _____ Policy no.: _____

Allergies (medications): _____

Allergies (other): _____

Conditions for which child is currently receiving treatment:

Other important medical information:

Dentist: _____

Address: _____

Phone: _____

Dental insurer/plan: _____ Policy no.: _____

Parents (or Legal Guardians)

Parent 1

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone or pager: _____ Email: _____

Additional Contact Information: _____

Parent 2

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone or pager: _____ Email: _____

Additional Contact Information: _____

Other Adult to Notify in Case Parent(s) Cannot Be Reached

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone or pager: _____ Email: _____

Additional Contact Information: _____

Authorization and Consent of Parent(s) or Legal Guardian(s)

I affirm that I have legal custody of the minor child indicated above. I give my authorization and consent for _____ [*name of supervising adult*], who is a(n) _____ [*title and name of organization, if appropriate*], to authorize necessary medical or dental care for my child. Such medical treatment shall be provided upon the advice of and supervised by any physician, surgeon, dentist, or other medical practitioner licensed to practice in the United States.

Parent 1's signature: _____ Date: _____

Parent 2's signature: _____ Date: _____

