

AUTHORIZATION TO CONSENT FOR TREATMENT OF A MINOR CHILD

Child's Full Name: _____

Age: _____ Birthdate: _____ Gender: Male or Female (circle one)

Social Security Number: _____ Phone: _____

Allergies: _____

Tetanus: (date of last immunization) _____

Medications currently taking (note name, dosage, and times taken): _____

Family Doctor (include phone number): _____

Recent illness / exposure to communicable disease (ie, measles, chicken pox, etc.): _____

Mother's Name: _____ Phone 1: _____
(Please include area code)

Phone 2: _____ Phone 3: _____
(Please include area code) (Please include area code)

Address: _____ City, ST, Zip _____

Father's Name: _____ Phone 1: _____
(Please include area code)

Phone 2: _____ Phone 3: _____
(Please include area code) (Please include area code)

Address: _____ City, ST, Zip _____

Insurance Company Name and Contract Number: _____

Name of responsible party in absence of parents or legal guardian: _____

Phone 1: _____ Phone 2: _____
(Please include area code) (Please include area code)

Address: _____ City, ST, Zip _____

(Over)

I (we) the parent(s) of the child named on reverse, hereby authorize _____,
to consent and agree to any emergency medical, surgical or dental care or treatment by any hospital,
emergency care provider, physician or dentist that he/she deems necessary and fit.

Parent(s) Signature(s): _____

Dated this, the _____ day of _____, _____

NOTARY PUBLIC:

State of _____

County of _____

I, the undersigned, a notary public in and for the said county and state, hereby certify that
_____, whose name is signed to the foregoing instrument and who is known to
me, acknowledged before me on this day that, being informed of the contents of the instrument,
_____ executed the same voluntarily on the day the same bears date.

Given under my hand and seal this _____ day of _____, _____

NOTARIAL SEAL

Notary Public

My Commission Expires This Date