

MEDICAL TREATMENT AUTHORIZATION LETTER	
GUARDIAN'S NAME	
GUARDIAN'S ADDRESS	
GUARDIAN'S HOME & CONTACT INFO	
<p>Date: _____</p> <p>To Whom It May Concern:</p> <p>Our minor child(ren) _____, will be traveling with and under the temporary guardianship of:</p> <p>Name(s): _____</p> <p>Relationship: _____</p> <p>Address: _____</p> <p>During the Dates of: _____</p> <p>In case of medical emergency during our absence, please try to reach the children's parents/guardians first at these numbers:</p> <p>Name: _____ Relationship: _____ Phone: _____</p> <p>Name: _____ Relationship: _____ Phone: _____</p> <p>In the event that none of the legal guardians noted above can be reached by phone during a medical emergency, we authorize (Names): _____</p> <p>_____ to make any medical decisions necessary to ensure proper treatment. We will assume all expenses related to the medical care for our child(ren).</p> <p>The following minors: _____ are covered by a medical insurance policy issued by: _____</p> <p>Insured Name: _____ Policy ID: _____</p> <p>Insurance Company Phone: _____</p> <p>Minors' Physician Contact Info: _____</p> <p>_____</p> <p>Thank you.</p>	
Parent/Guardian	Parent/Guardian