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 cu	rrently rece	iving treatment:	
Other important medical inform	ation:		
Dentist:			
Address:			
Phone:		D. U	
Dental insurer/plan:		Policy no.:	
Parents (or Legal Guardians)			
Parent 1			
Name:	_		
Address:			
Home phone:		Work phone:	
Cell phone or pager:			
Additional Contact Information	:		

Parent 2

Name:	
Address:	
Home phone:	Work phone:
	Email:
Additional Contact Information:	
Other Adult to Notify in Case Pare	nt(s) Cannot Be Reached
Name:	
Address:	
Home phone:	Work phone:
Cell phone or pager:	Email:
Additional Contact Information:	
I affirm that I have legal custody of the	ne minor child indicated above. I give my [name of supervising]
authorize necessary medical or dental	[name of supervising title and name of organization, if appropriate], to care for my child. Such medical treatment shall be rvised by any physician, surgeon, dentist, or other ice in the United States.
Parent 1's signature:	Date:
Parent 2's signature:	Date:
Certificate of Acl	knowledgment of Notary Public
State of)
) SS
County of)

On , before	re me,	, a notary		
public in and for said state, personally appeared				
	onally known to me (or proved to me on the			
satisfactory evidence) to be the person whose name is subscribed to the within				
instrument, and acknowledged to me that he or she executed the same in his or her				
authorized capacity and that by his or her signature on the instrument, the person, or the				
entity upon behalf of which the person acted, executed the instrument.				
	WITNESS my hand and official seal.			
	Notary Public for the State of			
	My commission expires			
[NOTARY SEAL]				