

## AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

**Child**

Full Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

**Doctor's Information**

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Office Phone: \_\_\_\_\_ Doctor's Emergency Phone: \_\_\_\_\_

Medical Insurer/Health Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Allergies (Other): \_\_\_\_\_

If applicable, please note the conditions for which the child is currently receiving treatment:

Note any other significant medical information:

\_\_\_\_\_

\_\_\_\_\_

**Dentist's Information**

Dentist's Name: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Dentist's Office Phone: \_\_\_\_\_ Dentist's Emergency Phone: \_\_\_\_\_

Dentist's Insurer/Health Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Parent(s)/Legal Guardian(s):****Parent #1:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Email: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

\_\_\_\_\_

**Parent #2:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Email: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

\_\_\_\_\_

**Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Email: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)**

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for \_\_\_\_\_ (hereafter "Supervising Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective commencing on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ and expiring on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
Parent #1's Signature

\_\_\_\_\_  
Parent #2's Signature

**CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC**

STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

This document was acknowledged before me on \_\_\_\_\_ [date] by \_\_\_\_\_ [name of principal].

[Notary Seal, if any]:

\_\_\_\_\_  
(Signature of Notarial Officer)

Notary Public for the State of \_\_\_\_\_

My commission expires: \_\_\_\_\_