Authorization for Medical Treatment of Minors

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an unexpected emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should be given to the adult(s) you have listed below to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person-physician, dentist or hospital representative

Minor Full Legal Name: ____

Home Address: ____

Date of Birth: ____________________ **Gender:** Female__________ Male__________

Physician's Name and Location of Practice: ____

Physician's Phone: ____

Medical Insurer/Health Plan: ______________________________ **Policy #:** ______________

Allergies to Medications: ____

Allergies (Other): ____

Please note all conditions for which the child is currently receiving treatment:

____

Note any other significant medical information:

____

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

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for

Name: ____

Address: ______________________________ **Phone:** ________________

Name: ____

Address: ______________________________ **Phone:** ________________

(hereafter "Designated Adult") to act in my behalf in authoring unexpected medical, dental, surgical care and hospitalization for the above named minor during the period of my absence, from Date: ______________________through Date:__________________. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor 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. This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care of hospitalization may be required.

Parent / Legal Guardian Signature: ______________________ **Printed Name:** ______________________

Parent Address: ______________________________ **Date:** ________________

Parent / Legal Guardian Signature: ______________________ **Printed Name:** ______________________

Parent Address: ______________________________ **Date:** ________________

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