AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name(s) of Minor(s) Birthdate Allergies or Special Conditions

I/We being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint:

Name Address Phone

Name Address Phone

to act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during my absence from:

Month Day Year through Month Day Year

PARENT/GUARDIAN

Signature

Address Date

PARENT/GUARDIAN

Signature

Address Date

HOSPITALIZATION COVERAGE

Insurance Company and/or Government Program I.D. or Contract Number

FAMILY PHYSICIAN and/or PEDIATRICIAN, ORTHOPEDIC SURGEON, ALLERGIST, DENTIST:
Name and Phone Number