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: ___________________