

POWER TO AUTHORIZE MEDICAL TREATMENT

I, _____ Residing at

(Parent or Guardian)

(Address) (City, State, Zip Code)

do hereby authorize the following person, _____

(Name)

(Address) (City, State, Zip Code)

to consent to such medical treatment as said person may deem to be in the best interest of my minor child,
_____ on any occasion when prompt treatment is
(Name of minor)

recommended by the treating physician and I am unavailable to consent to such medical treatment. This
authorization shall be effective from _____ to _____
(Date) (Date).

shall terminate at the end of one year at the signing of this document.

Executed this _____ day of _____, 2_____

(Parent or Guardian)

(Witness)

(Witness)

ACKNOWLEDGEMENT

STATE OF _____)

COUNTY OF _____)

On this _____ day of _____, 2_____, before me, _____
_____, a Notary Public in and for said state,
appeared Parent/Guardian of _____, a minor, known to me to be the person
who executed the foregoing Power to Authorize Medical Treatment and acknowledged to me that he executed the
same for the purposes therein stated, as his free act and deed.

In Testimony Whereof, I have hereunto set my hand and affixed my official seal.

Notary Public

My Commission Expires: _____

MEDICAL PERMISSION FORM FOR MINORS

As a parent or legal guardian, use this form in anticipation of being unavailable to authorize medical treatment of a minor. Mail or bring this in person to the Emergency Services Department of any hospital or facility.

Child's Name _____ Date of Birth _____

Parent/Guardian's Name _____

Address _____

Telephone# _____ Cell # _____

Next Relative _____ Telephone # _____

Physician _____ Telephone # _____

Dentist _____ Telephone # _____

Allergies _____

Medication (on presently) _____

Chronic Illness _____

Physical Handicaps _____

Other Information _____

Last Tetanus Shot Date _____

*Insurance Company _____

Mailing Address for Claims _____

Policy ID # _____ Group # _____

Employer Name _____

Employer Address _____

Employer Phone Number _____

*Please attach a copy of your child's insurance card(s) to this form.