Name of Child:_____**Grade**:_____

Medical Treatment Authorization Form for Minors

Child's Name: _____
Home Address: _____
Date of Birth:_____

Father/Guardian Name_____
Home Phone: _____ Business/or Cell:_____

Mother/Guardian Name_____
Home Phone: _____ Business/or Cell:_____

Emergency Contact (if parents not available):
Name:_____Phone:_____
Address:_____
Relationship to Child:_____

Information for Medical Treatment
Child's Doctor: _____Telephone:_____
Medical Insurance: _____ Policy #: _____
Responsible Party:_____
Allergies (medication, seasonal, other):_____
Please note Health Conditions and last tetanus shot:
_____

_____

I hereby authorize the release of above information, treatment, administration of anesthesia, and surgical treatment(s) for my minor child:

_____
In the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel within the hospital or physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary for my minor child.

Parent / Legal Guardian Signature: _____ Date: _____

Witness:_____Date:_____