**Child Medical Consent Form for Travel**

**Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**

**Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_
Passport Number (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Parent/Legal Guardian Information**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Child: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Accompanying Adult Information**

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Child: ☐ Grandparent ☐ Relative ☐ Friend ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Medical Consent**

**I, [Parent/Guardian Name], hereby authorize [Accompanying Adult Name] to obtain and authorize medical treatment for my child [Child’s Name] while traveling.**

**This authorization applies to:
☐ Emergency Medical Treatment
☐ Routine Medical Check-ups
☐ Prescription Medication
☐ Surgical Procedures
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Medical Provider Information**

**Primary Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Doctor’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Preferred Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**☐ I authorize the treating physician to provide necessary treatment if I cannot be reached.**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_**