## AUTHORIZATION FORM FOR MEDICAL TREATMENT OF MINORS

If your child needs medical, dental, health or hospital services, under the law, you as a parent must give permission. Naturally, if you are with your child, you can give permission as the need arises. You can prepare for those unexpected times when you are not with your child by filling out this authorization form. Using this form, you give permission to other adults to act for you, in your absence, regarding the treatment of your child.

This is a legal document. After you complete this form, give a copy to each adult you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult should present this document to the appropriate person - physician, dentist, or hospital representative.

When a true emergency exists, a child may be treated without parental consent. This will happen when a physician determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

IDENTIFICATION	
Name of Child	
Birth Date	
Date of Last Tetanus Shot	
Medications Now Being Taken	
Known Allergies	
Special Conditions	
HOSPITALIZATION COVERAGE FOR A Insurance Company or Governme Insurance ID or Contract #	ABOVE-NAMED MINOR ont Program
FAMILY PHYSICIAN	
Name	
Address	
Phone #	
I, being the parent of custody or legal gu	ardian of the above-named minor, do hereby appoint
Name (print)	
Address	
Phone #	
to act on my behalf in authorizing unexpe of the above-named minor in my absence	ected medical, dental, surgical care and hospitalization
Signature of Parent/Guardian	Date
Signature of Witness	Date

## AUTHORIZATION FORM FOR MEDICAL TREATMENT OF MINORS

This form is valid for a period of 90 days from the date signed.