AUTHORIZATION
FOR MEDICAL THREATMENTOF MINOR

Name of Minor _____ Birthdate _____

Allergies or Special Conditions _____

I being the parent of legal guardian of the above named minor do hearby appoint:

I being the parent or legal guardian of the above named minor do hearby appoint:

Name _____

Address _____

Phone _____

Name _____

Address _____

Phone _____

To act in my behalf in authorizing unexpected medical, dental, surgical and hospitalization for the above named minor during the period of my absence from:

Month _____ Day _____ Year _____

Through

Month _____ Day _____ Year _____

This document shall be presented to a physical, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization.

Parent/Guardian

Signature_____
Address_____

Date _____

Hospitalization coverage for above named minor:

Insurance CO. _____

ID or Contract No. _____

Family Physical

Name _____

Phone _____