# *MEDICAL TREATMENT AUTHORIZATION FOR A MINOR*

I, the undersigned parent, hereby grant _____, of
(printed name of temporary guardian)

_____,
(Street Address) (City) (State or Province) (Zip Code)

the authority to obtain medical treatment for the following child:

Name of child: _____
(printed name of child)

Birthdate: _____
(Child's birthdate)

The above care provider shall have the authorization to:

- obtain medical treatment and procedures for the child as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate health care providers.
- Obtain routine medical treatment from appropriate health care providers if symptoms of illness occur (e.g., fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.).

This grant of temporary authority shall begin on _____ , and shall
(Beginning date)
remain effective through _____.
(Ending date)

In case of emergency, the care provider should first try to contact the parent. If the parent cannot be reached, the care provider should then contact the following person:

Name: _____

Relationship: _____

Address: _____

Place of employment: _____

Preferred phone number: _____

Other phone number: _____

The care provider may provide the physician and other health care providers with the following health insurance information:

Insurance company: _____

Policy number: _____

Name of policy holder: _____

Dated: _____
(Date of Signature)

_____
(Signature)

_____
(Printed name of Parent)

Address: _____
(Parent Address)

_____
(City, State or Province, Zip code)

Preferred Phone: _____

Alternate Phone: _____