Medical Treatment for Minors-Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

Minor
Full Legal Name: _____

Home Address: _____

Date of Birth:_____ Gender: Female_____Male_____

Information for Medical Treatment Physician's Name and Location of Practice:
_____
_____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

Please note **all** conditions for which the child is currently receiving treatment:

_____
Note any other significant medical information:

_____
AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)
I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for _____ (hereafter "Designated Adult") to bring my child in for treatment. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective from _____ through _____.

Parent / Legal Guardian Printed Name: _____

Parent / Legal Guardian Signature: _____ Date: _____