**Skip the Line - Medical Clinic**

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# MINOR AUTHORIZATION TO TREAT FORM

Child's name: _____

Child's birth date: Month: _____ Day: _____ Year: _____

Child's known allergies (including medication, food, dye, latex, etc.):

1. _____
2. _____

Parent's/Guardian's Name(s): _____

Contact phone number: _____ (work) _____ (home)

Alternate phone number (if not at work or home): _____

Home Address:

_____
(Street)

_____
(City, State, Zip)

***I (we) the parent(s) or guardian(s) named above, authorize the following adult(s):***

1. _____ Relationship: _____
2. _____ Relationship: _____

***to consent to any necessary examination, medical diagnosis, treatment and/or care to be rendered to the above-named minor child under the adult supervision and on the advice of any health care professional.***

***Signed:***

Parent or Guardian: _____

Date: _____