Medical Treatment Authorization

Minor's Name: _____

Home Address: _____

Date of Birth: _____ Gender: _____

Medical Information

Primary Care Physician's Name: _____

Phone #: (____) _____

Medical Insurance Provider: _____ Policy #: _____

Allergies to Medications: _____

Medical Conditions for which the minor is receiving treatment: _____
_____

Prescription Drugs the minor is taking: _____
_____

Other pertinent medical information: _____
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S) as custodian of the aforementioned minor, I grant my authorization and consent for a designated adult to administer general first aid treatment for minor injuries or illnesses. If the injury or illness is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a licensed medical professional or institution. I authorize the designated adult to exercise best judgment upon the advice of medical or emergency personnel.

Effective Date: _____. Signed this _____day of_____, 20____.

Parent / Guardian Signature: _____

Printed Name: _____