

Authorization for Medical Treatment of Minors

Name of Minor	Birth Date	Identify Allergies or Special Conditions

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name:	Address:	Phone:
Name:	Address:	Phone:

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from: May 29th 2009 through May 31st 2010

Signature of Authorized Person: _____

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

Parent/Guardian Signature	Parent/Guardian Signature
Address	Address
Date	Date

Witness Signature	Witness Signature
Date	Date

Hospitalization / Insurance coverage for above named minor(s):

Insurance Company or Government Program	ID or Contract Number

Family Physician(s)

Name and Phone Number	Name and Phone Number

Fill out the above form carefully having your signature witnessed by someone other than the person you are designating to be responsible. Give the completed form to the adult you have named to act on your behalf. He/she should present the form to appropriate medical personnel at the time of treatment.