AUTHORIZATION

MINOR'S NAME:___________________________________

I am aware that my child may require treatment when I am not able to be present. In my

absence, I give to ____
(Individual name and relationship to patient)

my permission to authorize medical treatment of my child, _______________________.

-or-

In my absence, I give permission to ____
(Physician)

to examine and provide treatment to my child, _______________________.

In addition, the Physician has my permission to refer my child's emergent care to the appropriate service physician to provide optimal care for the check ups with immunizations, treatment of illness or injury.

This agreement begins ___________________ and ends_______________________.
Date Date

______________________________ ______________________ __________
Parent/Legal Representative Signature Relationship to Patients Date

____
Print Parent/Legal Representative Name

______________________________ __________
Witness to Signature Date

Medical, Physical, and Insurance Information
Please complete:

Date of birth______________ Wgt. of child_________ Hgt. of child_____________
Allergies:____
Medication(s):____
Previous surgery(ies):____
Chronic illness(es):____
Other pertinent medical information_______________________________________
____