TEMPORARY 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, ________________________.

<u>In addition, the Physician has my permission to immunize my child with the appropriate vaccines recommended by the Center for Disease Control.</u>

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_______________

Allergies:____

Current Medication(s):____

Other pertinent medical information____