



AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Patient/Minor(s)/MRN	DOB	Allergies/Special Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize the treatment of the above minor(s).

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

_____	_____	_____
Name	Address	Phone #
_____	_____	_____
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. I understand the listed person(s) above are the only authorized person(s) on file.

Patients under the age of 18 unaccompanied by parent(s) or legal guardian(s) or without a written authorization will not be seen.

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.

_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Witness	Date

Medical/Hospitalization Coverage for above Named Minor(s)

Insurance Company or Government Program ID or Contact #:

Primary _____

Physician Name: _____ Phone: _____