

Medical Authorization for Treatment of a Minor Child

Instructions: Prepare one of these forms for EACH of your minor children, and have each form notarized.

Child's Full Legal Name: _____

Child's Date of Birth: _____ Age: _____ Gender: _____

Child's Allergies to Medications: _____

Child's Other Allergies: _____

Child's Blood type (if known) _____

If applicable, please note any conditions for which the child is currently receiving treatment:

Note any other significant medical information:

Parent(s)/Legal Guardian(s):

Parent #1:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information:

Parent #2:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information:

Child's Primary Physician

Doctor's Name: _____

Doctor's Address: _____

Doctor's Office Phone: _____ Doctor's Emergency Phone: _____

Medical Insurer/Health Plan: _____ Policy #: _____

Insurer/Health Plan's phone number: _____

Child's Dentist

Dentist's Name: _____

Dentist's Address: _____

Dentist's Office Phone: _____ Dentist's Emergency Phone: _____

Dentist's Insurer/Health Plan: _____ Policy #: _____

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Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for _____
(hereafter "Supervising Adult(s)") to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult(s) to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, operation, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult(s) in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Parents/guardians will hold the Supervising Adult(s) harmless and protect them from lawsuits, if any, arising out of the custodian's actions in caring for the child as long as the Supervising Adult(s) exercise their "best efforts" and are not guilty of intentional wrongdoing or gross negligence.

Furthermore, any medical expenses incurred in treating the minor can be filed with the above insurance company. Any amount not covered by insurance will be the responsibility of the parents/guardians.

This authorization is effective commencing on the _____ day of _____,
20____ and expiring on the _____ day of _____, 20____.

Signed this _____ day of _____, 20____.

Parent/Legal Guardian #1's Signature

Parent/Legal Guardian #2's Signature

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CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF _____
COUNTY OF _____

This document was acknowledged before me on _____ [date]
by _____ [name of principal].

[Notary Seal, if any]:

(Signature of Notarial Officer)

Notary Public for the State of _____

My commission expires: _____