



**Authorization for Minor's Medical Treatment**

**Child**

Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in school: \_\_\_\_\_  
Doctor (or HMO): \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: \_\_\_\_\_  
Medical Insurer/Health Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Allergies (medications): \_\_\_\_\_  
Allergies (other): \_\_\_\_\_  
Conditions for which child is currently receiving treatment: \_\_\_\_\_

Other important medical information: \_\_\_\_\_

Dentist: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: \_\_\_\_\_  
Dental Insurer/Plan: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Parents (or Legal Guardians)**

**Parent 1**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone or pager: \_\_\_\_\_ Email: \_\_\_\_\_  
Additional Contact Information: \_\_\_\_\_

**Parent 2**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone or pager: \_\_\_\_\_ Email: \_\_\_\_\_  
Additional Contact Information: \_\_\_\_\_

**Other Adult to Notify in Case Parent(s) Cannot Be Reached**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone or pager: \_\_\_\_\_ Email: \_\_\_\_\_  
Additional Contact Information: \_\_\_\_\_

**Authorization and Consent of Parent(s) or Legal Guardian(s)**

I affirm that I have legal custody of the minor child indicated above. I give my authorization and consent for \_\_\_\_\_ [name of supervising adult], who is a(n) \_\_\_\_\_ [title and name of organization, if appropriate], to authorize necessary medical or dental care for my child. Such medical treatment shall be provided upon the advice of and supervision by any physician, surgeon, dentist or other medical practitioner licensed to practice in the United States.

Parent 1's signature: \_\_\_\_\_ Date: \_\_\_\_\_