

# Medical Treatment Authorization

Minor's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

## Medical Information

Primary Care Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Medical Conditions for which the minor is receiving treatment:  
\_\_\_\_\_

Prescription Drugs the minor is taking:  
\_\_\_\_\_

Other pertinent medical information:  
\_\_\_\_\_

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S) As custodian of the aforementioned minor, I grant my authorization and consent for a designated adult to administer general first aid treatment for minor injuries or illnesses. If the injury or illness is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a licensed medical professional or institution. I authorize the designated adult to exercise best judgment upon the advice of medical or emergency personnel.

Effective Date: \_\_\_\_\_.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Parent / Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_