Authorization to Treat Minor Child

FROM: _____
Full Name of Parent or Guardian

TO: _____
Name of Adult Responsible for Child(ren)

I, _____ of
Full Name(of Parent or Guardian)

_____
Address and Phone

do hereby authorize _____ of
Name of Adult Responsible for Child(ren)

_____
Address and Phone

to decide upon and consent to the rendering of any medical diagnosis and treatment which s/he deems in the best interest of the health and welfare of our child(ren):

_____

_____
Name(s) of Child(ren)

This authorization shall be effective during such period of time as I may for any reason not be available to give my consent to any medical diagnosis or treatment for our child(ren).

Executed this _____ day of _____, 20____.

_____ _____
Witness Signature of Parent or Guardian

Child(ren)'s Medical Information
(Please include for all children)

Child's Pediatrician/Nurse Practitioner: _____
Allergies: _____
Medications: _____
Special Medical Problems/ Concerns: _____

LEAVE THIS FORM WITH THE ADULT WHO CARES FOR YOUR CHILD(REN) IN YOUR ABSENCE