

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

NAME OF MINOR _____ BIRTH DATE _____

IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

I/WE, BEING THE PARENTS(S) OR LEGAL GUARDIANS(S) OF THE ABOVE NAMED MINOR, DO HEREBY APPOINT:

NAME	ADDRESS	PHONE
1. _____	_____	_____
2. _____	_____	_____

TO ACT IN MY/OUR BEHALF IN AUTHORIZING UNEXPECTED MEDICAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE NAMED MINOR(S) DURING THE PERIOD OF MY/OUR ABSENCE FROM: MONTH/DAY/YEAR Through MONTH/DAY/YEAR

From 4/01/10 Through 7/31/10

THIS DOCUMENT SHALL BE PRESENTED TO A PHYSICIAN, DENTIST OR APPROPRIATE HOSPITAL REPRESENTATIVE AT SUCH TIME AS UNEXPECTED MEDICAL, DENTIST, SURGICAL CARE OR HOSPITALIZATION MAY BE REQUIRED.

PARENT GUARDIAN SIGNATURE	ADDRESS	PHONE
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WITNESS SIGNATURE	ADDRESS	PHONE
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HOSPITAL COVERAGE FOR THE ABOVE NAMED MINOR(S)

INSURANCE COMPANY	I.D. OR CONTRACT NUMBER
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FAMILY PHYSICIAN(S):

1. _____
NAME AND NUMBER

2. _____
NAME AND NUMBER