AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR CHILD IN ABSENCE OF PARENT/GUARDIAN

During my absence from ____________________ to ____________________, I hereby delegate:

Name ______________________________ and/or Name ______________________________

Address ______________________________ Address ______________________________

______________________________ ______________________________

Phone #'s ______________________________ Phone #'s ______________________________

______________________________ ______________________________

To obtain and authorize treatment of the following minor children:

Name	Birthdate	Allergies	Last tetanus	Chronic Illnesses	Current Meds

Family Physician:

Name: ______________________________

Address: ______________________________

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Phone: ______________________________

Specialty Physician:

Name: ______________________________

Address: ______________________________

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Phone: ______________________________

Insurance information helps facilitate proper billing in your absence:

Insurance Company ______________________________

Policy # ______________________________ Group # ______________________________

Name of insured ______________________________ Birthdate ______________________________

Signature of Parent/Guardian ______________________________

Witness ______________________________

Date ______________________________