

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: _____ Specialty Physician: _____

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Insurance information helps facilitate proper billing in your absence:

Insurance Company _____

Policy # _____ Group # _____

Name of insured _____ Birthdate _____

Signature of Parent/Guardian _____

Witness _____

Date _____