

Medical Authorization

As a parent/guardian, I do hereby authorize the treatment of my minor child/children listed below by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Names of Children

List of allergies, medications, or other pertinent information

Emergency Contacts

Health Insurance Information

Company:

Policy:

Group:

ID#:

Family Physician Name:

Phone:

Address:

Date: _____

Signature: _____

Print Name: _____