MEDICAL TREATMENT AUTHORIZATION FOR A MINOR

I, the undersigned parent, hereby grant _____,
(name of adult bringing child)
_____ the authority to obtain medical treatment for the following child:
(relationship to minor)

Minor Patient: _____

Date of Birth: _____

- **Obtain medical treatment and procedures for the child as may be appropriate in emergency circumstances, including treatment by physicians, clinic personnel, and other appropriate health care providers.**

- **Obtain routine medical treatment from appropriate health care providers.**

This grant of temporary authority shall begin on _____, and shall remain effective until terminated by the undersigned.

Parents contact information:

Mother's Name: _____ Father's Name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Parent Signature: _____ Date: _____