

## **Medical Treatment Authorization**

Minor's Name:	
Home Address:	
Date of Birth:	Gender:
Medical Information	
Primary Care Physician's Name:	
Phone #: ()	
Medical Insurance Provider:	Policy #:
Allergies to Medications:	
Medical Conditions for which the minor is receiving treatment:	
Prescription Drugs the minor is taking:	
Other pertinent medical information:	
AUTHORIZATION AND CONSENT OF PARENT(S custodian of the aforementioned minor, I grant my a designated adult to administer general first aid treat If the injury or illness is severe, I authorize him or hip personnel to attend, transport, and treat the minor a care deemed advisable by a licensed medical professionated adult to exercise best judgment upon the personnel.	authorization and consent for a attment for minor injuries or illnesses. Her to seek professional emergency and to issue consent for any medical essional or institution. I authorize the
Effective Date:	
Signed thisday of, 20	
Parent / Guardian Signature:	
Printed Name:	