

# Medical Treatment Authorization and Consent

I/We, \_\_\_\_\_, being the (Check one)  parent(s)   
legal guardian(s) of \_\_\_\_\_ [Child] authorize \_\_\_\_\_  
[Caregiver] to seek, obtain and consent to: (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Routine medical care and treatment   | <input type="checkbox"/> Hospitalization           |
| <input type="checkbox"/> Emergency medical care and treatment | <input type="checkbox"/> Blood transfusions        |
| <input type="checkbox"/> Surgery                              | <input type="checkbox"/> Dental care and treatment |
| <input type="checkbox"/> Other: _____                         |  |

for \_\_\_\_\_ [Child] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my/our child is in the care of \_\_\_\_\_ [Caregiver], my/our child's: (Check one)

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Grandmother  | <input type="checkbox"/> Baby-sitter   |
| <input type="checkbox"/> Grandfather  | <input type="checkbox"/> Family friend |
| <input type="checkbox"/> Aunt         | <input type="checkbox"/> Teacher       |
| <input type="checkbox"/> Uncle        |  |
| <input type="checkbox"/> Nanny        |  |
| <input type="checkbox"/> Other: _____ |  |

and is effective \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ until (Check one)  \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  revoked by me/us.

## Child's Information

Child's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Female  Male

## Parent/Guardian's Information

Parent's/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number (H): \_\_\_\_\_ Phone Number (C): \_\_\_\_\_

Phone Number (W): \_\_\_\_\_ Email: \_\_\_\_\_

## Parent/Guardian's Information

**Parent's/Guardian's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number (H):** \_\_\_\_\_ **Phone Number (C):** \_\_\_\_\_

**Phone Number (W):** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Emergency Contact Person's Information**

**Emergency Contact's Name:** \_\_\_\_\_

**Phone Number (H):** \_\_\_\_\_ **Phone Number (C):** \_\_\_\_\_

**Phone Number (W):** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Alternative Emergency Contact Person's Information**

**Alternative Emergency Contact's Name:** \_\_\_\_\_

**Phone Number (H):** \_\_\_\_\_ **Phone Number (C):** \_\_\_\_\_

**Phone Number (W):** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Child's Health Information**

**Health Conditions** (e.g. Asthma, Diabetes):  
\_\_\_\_\_

**Allergies** (e.g. to Medications, Food):  
\_\_\_\_\_

**Prescription Medications:** \_\_\_\_\_

**Date of Last Tetanus Injection/Booster:** \_\_\_\_\_

**Child's Medical Care Information**

**Physician/ Pediatrician:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Dentist/Orthodontist:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Preferred Medical Facility:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Policy/Group Number:** \_\_\_\_\_ **Policy Holder:** \_\_\_\_\_

**Signature of Parent/Guardian**

**Signature**  
  
\_\_\_\_\_

---

**Print Name**

**Date**

---

**Signature**

---

**Print Name**

**Date**

**Witness**

**Witness 1 Signature**

**Print Name**

**Date**

**Address**

**Witness 2 Signature**

**Print Name**

**Date**

**Address**

**Notary Acknowledgment**

State of \_\_\_\_\_  
County of \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ in the year 20\_\_\_\_ before me,  
\_\_\_\_\_, appeared \_\_\_\_\_, who is personally known to me  
or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this  
instrument, and acknowledged that he or she executed it.

**Notary Seal**

\_\_\_\_\_  
(Signature of Notary Public)

My Commission Expires: \_\_\_\_\_(Date)