



Authorization for Medical Treatment of Minors

Name(s) of Minor(s)

Birthdate

Allergies or Special Conditions

I/We being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint:

to act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) on July 7, 22 and August 5, 2015

PARENT/GUARDIAN

PARENT/GUARDIAN

Signature *Date*

Signature *Date*

Address

Address

HOSPITALIZAION COVERAGE

Insurance Company and/or Government Program

FAMILY PHYSICIAN and PEDIATRICIAN, ORTHOPEDIC SURGEON, ALLERGIST, DENTIST
