Medical Treatment Authorization and Consent

I, _____[Full Legal Name of Parent/Guardian], being the [parent/legal guardian] of _____ [Child's Full Name] authorize _____[Full Name of Caregiver] to seek, obtain, consent to [routine medical care and treatment/emergency medical care and treatment/surgery/hospitalization/blood transfusions/ dental care and treatment/ other] for _____[Child's Full Name] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of _____[Full Name of Caregiver]and is effective _____[Start Date] until _____[End Date]

Child's Information

Child's Full Name:_____
Address:_____
Date of Birth:_____Age:_____

Parent/Guardian's Information

Parent's/Guardian's Name 1:_____
Address:_____
Phone Number (H):_____Phone Number (C)_____

Parent's/Guardian's Name 2:_____
Address:_____
Phone Number (H):_____Phone Number (C)_____

Child's Health Information

Health Conditions (e.g. Asthma, Diabetes):_____
Allergies (e.g. to Medications, Food):_____
Prescription Medication(s):_____
Date of Last Tetanus Injection/Booster:_____

Child's Medical Care and Insurance Information

Physician/Pediatrician:_____ Phone Number:_____
Dentist/Orthodontist:_____ Phone Number:_____
Preferred Medical Facility:_____
Insurance Company:_____
Policy/Group Number:_____ Policy Holder:_____

Signature of Parent Guardian

Signature:_____ Date:_____
Print Name:_____