AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

NAME OF MINOR(S)	BIRTHDATE(S)	IDENTIFY ALLERGIES OR SPECIAL ITEMS:

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

NAME:	Phone#	Address:
NAME:	Phone#	Address:

To act in my/our behalf in authorizing unexpected medical, dental surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from:

Month/Day/Year	Through	Month/Day/Year

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

PARENT/GUARDIAN	PARENT/GUARDIAN
Name:	Name:
Signature:	Signature:
Address:	Address:
Phone#:	Phone #:
Date:	Date:
WITNESS:	**WITNESS:**
Name:	Name:
Signature:	Signature:
Address:	Address:
Phone#:	Phone #:
Date:	Date:

HOSPITALIZATION COVERAGE FOR ABOVE MENTIONED NAMED MINOR(S):

INSURANCE COMPANY OR GOVERNMENT PROGRAM:	ID OR CONTRACT NUMBER:
FAMILY PHYSICIAN (NAME):	
PHYSICIAN ADDRESS:	
PHYSICIAN PHONE #:	