

Authorization to Consent to Medical Care of a Minor Child

Child's Healthcare Information

Birthdate _____ SS# _____

(Address)

(City, State, Zip)

Phone _____

Pediatrician

(Name and Phone)

Dentist

(Name and Phone)

Allergies _____

Date of Last Tetanus _____

Medical History (include surgeries) _____

Current Medications _____

Guarantor Information

Father Mother Legal Guardian

(Insured Name)

(Address)

(City, State, Zip)

Phone _____

(Name of employer)

(Address of employer)

Phone _____

Insurance Carrier _____

Policy Number _____

Group Name _____

I _____
(Undersigned)

(Address)

the parent or person having legal custody or the legal guardian of

(Minor's Name) (Age)

(Address)

hereby authorize _____
(Name of Person to Whom Child is Entrusted)

(Address)

to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor child upon the advice of a duly licensed physician or dentist, including, but not limited to, the right to consent to the administration of prescription or non-prescription medicine or drugs upon the advice of such physician, surgeon or dentist; and to rely on the advice of a duly licensed physician, surgeon or dentist to prudently exercise their professional judgment and to choose the necessary treatment from any available alternatives and to render such care and perform such treatment as they in their professional judgment determine to be in the best interests of the above named child; and to generally take or agree to such steps that are necessary to insure proper medical or dental care to said minor child in case of an emergency.

Date _____

(Signature of Parent or Person Having Legal Custody or Legal Guardian)

(Signature of Person to Whom Child is Entrusted)