Temporary Medical Authorization for Minors

Minor's Information

Full Name:

Date of Birth:

Address:

Parent/Guardian Information

Name:

Phone Number:

Relationship to Minor:

Temporary Guardian/Responsible Adult

Name:

Phone Number:

Authorization Details

I hereby authorize the above-named temporary guardian/responsible adult to seek and consent to medical treatment for my minor child listed above in my absence. This authorization is valid from:

Start Date:

End Date:

Parent/Guardian Signature:

Date: