Minor Medical Treatment Authorization

Minor's Information

Full Name of Minor: _____

Date of Birth: _____

Home Address: _____

Parent/Guardian Information

Name of Parent/Legal Guardian: _____

Contact Number: _____

Authorization

I hereby authorize the following individual(s) to seek and consent to medical treatment for my child:

Authorized Person(s) Name: _____

Limitations (if any)

Please list any limitations or special instructions:

_____

Signature

Parent/Guardian Signature: _____

Date: _____