Authorization for Medical Treatment Form

SAMPLE

Authorization for Medical Treatment

I (We) _____
Parent(s)/Guardian(s) Names

_____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

_____ _____
(Daytime phone #) (Evening phone #)

Do hereby state that I am (we are) the parent(s)/guardian(s) having legal custody of:

_____ is a minor child, born on _____.
(Child's name) (Child's date of birth)

If I/we cannot be reached I/we authorize the following person to authorize medical services for my(our) child

_____an adult who works at _____
(School Representative) (School and Address)
to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

This authorization will expire on _____

Signed _____ Date: _____

Medical Information

Child's allergies, if any: (medication, insects, food, etc.) _____

Usual Treatment:_____

Existing Medical problems or conditions, if any
_____

Medications your child is taking (list schedule on reverse)
_____

Child's Doctor _____ Phone Number _____

_____ _____ _____
(Insurance Company) (Group #) (ID #)

Date of last Tetanus shot _____

In case of emergency a parent or guardian we can reach:

Name _____ Relationship to child _____

Daytime phone number _____ Evening phone number _____

If a parent is not available, please contact:

Name _____ Relationship to child _____

Daytime phone number _____ Evening phone number _____

Schedules for Medications

Student Name	*Medication(s)*	*Period(s) to be dispensed (pre/post meals, hour of sleep, PRN…)*