



**AUTHORIZATION TO PROVIDE MEDICAL CARE**

TO ANY HOSPITAL OR MEDICAL PROVIDER:

This document constitutes my authorization and consent for you to provide any and all medical and nursing care which you deem necessary or appropriate and in the best interest of my child:

Child's Full Name: \_\_\_\_\_

Date of Birth(Month/Day/Year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I represent to you that I have legal authority to authorize and to consent to such medical care. I further authorize the bearer of this document to execute on my behalf any and all Consent to Treatment forms, including informed consent forms for invasive procedures, which you may require as a condition of treatment.

This authorization is effective this \_ day of \_\_\_\_\_,20\_\_ and shall remain in effect until I provide you with written notice of revocation.

My child's personal physician is:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ Tele: (\_\_\_\_) \_\_\_\_\_

My child's insurance information is:

Insurer/HMO/PPO: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

My child's **ALLERGIES** are: \_\_\_\_\_

My child's **SIGNIFICANT MEDICAL CONDITIONS** and/or **RECENT INJURIES** are: (use back of form if necessary)

\_\_\_\_\_

Date of my child's last tetanus shot: \_\_\_\_\_

A copy of this Authorization shall have the same force and effect as the original.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ Business Phone:(\_\_\_\_) \_\_\_\_\_

Emergency contact other than parent: Name: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_