AUTHORIZATION FOR MEDICAL CARE

I _____ hereby authorize _____
(Name of parent or guardian) *(Name of representative)*
and/or _____
(Name of representative)
to give consent for treatment of my child _____
in the event of illness or injury. *(Name of child)*

This authorization is effective from _____ to _____.
(date) *(date)*

Our child's Primary Care Physician is _____

- List of current medication and dosages: (if none, write NONE) _____
  _____
  _____
  _____
- Allergies: (if none, write NONE) _____
  _____
  _____
  _____
- Medical History: (if none, write NONE) _____
  _____
  _____
  _____
  _____
- Date of last Tetanus Shot: _____
- Insurance Information:

(Name) _____
(Address) _____
(Policy Number) _____
(Insurance – Employer) _____

_____
(Signature of Parent or Guardian)

_____
(Date)

_____