schreiber allergy

Authorization to Consent to Medical Treatment of a Minor

I/We, the undersigned parent(s) or legal guardian(s) of the minor child identified below, authorize the person named in this document to consent to medical treatment for the child when I/we can not be reached..

1. Parent/Legal Guardian Information

Parent/Guardian Full Name: _____

Address: _____

Phone Number: _____

Email: _____

2. Minor Child Information

Child's Full Legal Name: _____

Date of Birth: _____

Known Allergies / Medical Conditions / Medications:

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3. Authorized Caregiver Information

I/We authorize the following person to obtain and consent to medical, dental, surgical, hospital, and emergency treatment for the above-named minor child:

Authorized Adult's Full Name: _____

Relationship to Child: _____

Address: _____

Phone Number: _____

4. Authorization

This authorization includes consent for:

- Medical treatment
- Diagnostic testing
- Prescription medication

This authorization does **not** grant custody or legal guardianship rights.

5. Effective Dates

This authorization is effective beginning on:

Start Date:
_____

and expires on:

End Date:

_____ (one year from start date)

unless revoked earlier in writing.

6. Emergency Contacts

_____

Emergency Contact: _____

7. Signatures

Phone:

I certify that I am the parent or legal guardian of the above-named child and have authority to execute this authorization.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____