



**Authorization & Consent of Parent(s) or Legal Guardian(s)**

I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_, a Minor. I hereby give my consent and authorization for medical care rendered to the Minor, including emergency and non-emergency diagnostic procedures and surgical and dental care. I further voluntarily consent and authorize \_\_\_\_\_ (hereinafter "Caregiver") to administer treatment for any basic injuries or illnesses experienced by the Minor. If the injuries or illnesses experienced are more serious, I consent to and authorize the Caregiver to take appropriate measures, including summoning emergency medical personnel and the authority to issue consent for necessary medical care as deemed by any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. This includes any X-ray, anesthetic, blood transfusion, medication, or any other medical treatment.

In making medical decisions on my behalf for the benefit of the Minor, I direct the caregiver to attempt to contact me. Additionally, I authorize the health care provider to discuss in full with the Caregiver any medical information that is required to help the treatment of the Minor. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of the Minor and that I assume financial responsibility for such medical care.

It is understood that this authorization is given in advance of any such medical treatment, but it is given to provide authority and power on the part of the Caregiver in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Signed, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

This authorization is effective through \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

PRINTED NAME OF PARENT/LEGAL GUARDIAN \_\_\_\_\_ PRINTED NAME OF WITNESS \_\_\_\_\_

SIGNATURE OF PARENT/LEGAL GUARDIAN \_\_\_\_\_ SIGNATURE OF WITNESS \_\_\_\_\_

PRIMARY PHONE OF PARENT/LEGAL GUARDIAN \_\_\_\_\_ WORK PHONE OF PARENT/LEGAL GUARDIAN \_\_\_\_\_

**Minor's Pertinent Health Information**

MINOR'S FULL LEGAL NAME \_\_\_\_\_ MINOR'S DATE OF BIRTH \_\_\_\_\_

MEDICATIONS \_\_\_\_\_ ALLERGIES \_\_\_\_\_

HOME ADDRESS (NUMBER AND STREET) \_\_\_\_\_

CITY \_\_\_\_\_ STATE/PROVINCE \_\_\_\_\_ ZIP/POSTAL CODE \_\_\_\_\_ COUNTRY \_\_\_\_\_

HEALTH INSURANCE CARRIER \_\_\_\_\_ HEALTH INSURANCE POLICY # & GROUP # \_\_\_\_\_

DATE OF LAST TETANUS SHOT \_\_\_\_\_ OTHER PERTINENT MEDICAL HISTORY \_\_\_\_\_