

# POWER TO AUTHORIZE MEDICAL TREATMENT

I, \_\_\_\_\_ Residing at  
(Parent or Guardian)  
\_\_\_\_\_  
(Address) (City, State, Zip Code)

do hereby authorize the following person, \_\_\_\_\_  
(Name)  
\_\_\_\_\_  
(Address) (City, State, Zip Code)

to consent to such medical treatment as said person may deem to be in the best interest of my minor child,  
\_\_\_\_\_ on any occasion when prompt treatment is  
(Name of minor)

recommended by the treating physician and I am unavailable to consent to such medical treatment. This  
authorization shall be effective from \_\_\_\_\_ to \_\_\_\_\_  
(Date) (Date).

shall terminate at the end of one year at the signing of this document.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_  
\_\_\_\_\_  
(Parent or Guardian)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Witness)

## ACKNOWLEDGEMENT

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

On this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_, before me, \_\_\_\_\_  
\_\_\_\_\_, a Notary Public in and for said state,  
appeared Parent/Guardian of \_\_\_\_\_, a minor, known to me to be the person  
who executed the foregoing Power to Authorize Medical Treatment and acknowledged to me that he executed the  
same for the purposes therein stated, as his free act and deed.

In Testimony Whereof, I have hereunto set my hand and affixed my official seal.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

## MEDICAL PERMISSION FORM FOR MINORS

As a parent or legal guardian, use this form in anticipation of being unavailable to authorize medical treatment of a minor. Mail or bring this in person to the Emergency Services Department of any hospital or facility.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone# \_\_\_\_\_ Cell # \_\_\_\_\_

Next Relative \_\_\_\_\_ Telephone # \_\_\_\_\_

Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone # \_\_\_\_\_

Allergies \_\_\_\_\_

Medication (on presently) \_\_\_\_\_

Chronic Illness \_\_\_\_\_

Physical Handicaps \_\_\_\_\_

Other Information \_\_\_\_\_

Last Tetanus Shot Date \_\_\_\_\_

\*Insurance Company \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone Number \_\_\_\_\_

\*Please attach a copy of your child's insurance card(s) to this form.