**Medical Treatment Authorization and Consent**

, being the \_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_ authorize \_\_\_\_\_\_\_\_\_ to seek, obtain and consent to \_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_ as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of \_\_\_\_\_\_\_\_\_ my child’s \_\_\_\_\_\_\_\_\_ and is effective \_\_\_\_\_\_\_\_\_ until .

**Child’s Information**

Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_

**Parent/Guardian’s Information**

Parent’s/Guardian’s Name 1: \_\_\_\_\_\_\_\_\_  
Phone Number (H): \_\_\_\_\_\_\_\_\_ Phone Number (C): \_\_\_\_\_\_\_\_\_  
Phone Number (W): \_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Name 2: \_\_\_\_\_\_\_\_\_  
Phone Number (H): \_\_\_\_\_\_\_\_\_ Phone Number (C): \_\_\_\_\_\_\_\_\_  
Phone Number (W): \_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_

**Emergency Contact Person’s Information**

Emergency Contact’s Name: \_\_\_\_\_\_\_\_\_  
Phone Number (H): \_\_\_\_\_\_\_\_\_  
Phone Number (W): \_\_\_\_\_\_\_\_\_  
Phone Number (C): \_\_\_\_\_\_\_\_\_  
Email: \_\_\_\_\_\_\_\_\_

**Child’s Health Information**

Health Conditions (e.g. Asthma, Diabetes): \_\_\_\_\_\_\_\_\_  
Allergies (e.g. to Medications, Food): \_\_\_\_\_\_\_\_\_  
Prescription Medications: \_\_\_\_\_\_\_\_\_  
Date of Last Tetanus Injection/Booster: \_\_\_\_\_\_\_\_\_

**Child’s Medical Care and Insurance Information**

Physician/Pediatrician: \_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_

**SIGNATURE OF PARENT/GUARDIAN**

Signature \_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_  
Print Name \_\_\_\_\_\_\_\_\_