AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

NAMES OF MINORS	BIRTHDATES	IDENTIFY ALLERGIES AND/OR SPECIAL CONDITIONS

I/We, being the parent(s) of the above named minor(s), do hereby appoint:

Name:	Address:	Phone:
Name:	Address:	Phone:

... to act on my behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence from:

_____ Through _____

Month/Day/Year Month/Day/Year

This document shall be presented to a physician, dentist, or appropriate hospital representitive at such a time as unexpected medical, dental, surgical care of hospitalization may be required:

Parent/Guardian		Parent/Guardian	
Signature	Date	Signature	Date
Address		Address	
Witness		**Witness**	
Signature		Signature	

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED MINOR(S):

Insurance Company or Government Program	ID or Contract Number

FAMILY PHYSICIAN:

NAME	PHONE NUMBER