Minor Medical Treatment Authorization Waiver

Minor's Full Name:

_____

Date of Birth:

_____

Parent/Guardian Name:

_____

Authorization

I, the undersigned, am the parent or legal guardian of the minor named above. I hereby authorize any licensed physician, medical staff, hospital, or allied health professional to administer necessary medical/first aid treatment to the above-named minor in the event of an emergency when I cannot be reached.

Known Allergies/Medical Conditions

_____

Current Medications

_____

Parent/Guardian Phone Number:

_____

Signature of Parent/Guardian:

_____

Date:

_____

This authorization will remain effective until revoked in writing by the parent or legal guardian.