Minor Medical Authorization Waiver Form

This form authorizes the designated adult to authorize medical treatment for the minor named below in the case of emergency when the parent(s) or legal guardian(s) cannot be reached.

Minor Information

Full Name of Minor

Date of Birth

MM/DD/YYYY

Age

Address

Parent/Guardian Information

Parent/Guardian Name

Phone Number

Email Address

Authorized Adult

Name of Authorized Adult

Phone Number

Medical Information

Physician's Name

Physician's Phone

Known Allergies

Special Medical Conditions

Medications Currently Taken

Authorization and Waiver

I hereby authorize the above named adult to act in my behalf in any situation requiring medical attention, and to authorize medical treatment when I cannot be reached. I release all medical professionals and administrators from any liability arising from medical treatment of my child.

Parent/Guardian Signature

Date

MM/DD/YYYY