

**AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT  
FOR MINOR CHILD TO ANY MEDICAL FACILITY**

Date: \_\_\_\_\_

Authorization is hereby given to \_\_\_\_\_  
Name of Responsible Person

to consent to emergency treatment for my child \_\_\_\_\_  
Name of Child

and to proceed with such treatment that may be necessary in that we the parents are not available at the time of the injury or illness.

Authorization is also given for admission to the hospital, if at the time of injury or illness, in our absence, admission to the hospital is advised by the attending physician.

Child's Birth Date \_\_\_\_\_

Date of Child's Last Tetanus Immunization Injection: \_\_\_\_\_

Child's Allergies and Chronic Illness: \_\_\_\_\_

Telephone Number of Physician: \_\_\_\_\_

Address & Telephone Number where Parent(s) might be reached: \_\_\_\_\_

As Parents, we promise to pay whatever costs are not covered by:

\_\_\_\_\_  
Name of Insurance

\_\_\_\_\_  
Number on Card

\_\_\_\_\_  
Signature of Responsible Party during Parent's absence as named above

\_\_\_\_\_  
Signature of Child's Parent(s)

Subscribed and Sworn to before me,  
on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
Witness my hand and official Seal.

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

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