

## MEDICAL AUTHORIZATION FORM

### I. Family Information

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Home phone \_\_\_\_\_  
Work phone \_\_\_\_\_

Parent's Name \_\_\_\_\_ Home phone: \_\_\_\_\_  
Work phone: \_\_\_\_\_

### II. Additional persons who can be called in an emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship \_\_\_\_\_

### III. Physician to be called in emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

If physician cannot be reached, what action should be taken?

\_\_\_\_\_

### IV. Medical insurance information:

Group Name/Plan Number: \_\_\_\_\_  
Name and Social Security # of Insured (or person responsible for payment):  
\_\_\_\_\_

### V. Allergies or other medical limitations:

\_\_\_\_\_

**VI. Permission for medical treatment:** *Administrative procedures vary among medical personnel and medical facilities with regard to provision of medical care for a child in the absence of the parent. The exact procedure required by the physician or hospital to be used in emergencies should be verified in advance.* In case of accident or emergency, I authorize my child's caregiver or other authorized adults to take my child to the above-named physician or to the nearest hospital for emergency treatment. I authorize the administration of measures as are deemed necessary for the safety and protection of the child.

**Parent's Signature**

**Date**

\_\_\_\_\_

\_\_\_\_\_