AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

Child
Full Legal Name: _____
Date of Birth: _____ Age: _____ Gender: _____

Doctor's Information
Doctor's Name: _____
Doctor's Address: _____
Doctor's Office Phone: _____ Doctor's Emergency Phone: _____
Medical Insurer/Health Plan: _____ Policy #: _____
Allergies to Medications: _____
Allergies (Other): _____
If applicable, please note the conditions for which the child is currently receiving treatment:
_____
Note any other significant medical information:
_____
_____

Dentist's Information
Dentist's Name: _____
Dentist's Address: _____
Dentist's Office Phone: _____ Dentist's Emergency Phone: _____
Dentist's Insurer/Health Plan: _____ Policy #: _____

Parent(s)/Legal Guardian(s):

Parent #1:
Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

Parent #2:
Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:
Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for _____ (hereafter "Supervising Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective commencing on the _____day of _____, 20_____ and expiring on the _____day of _____, 20____.

Signed this _____day of_____, 20 ____.

_____
Parent #1's Signature

_____
Parent #2's Signature

State of California
County of **Los Angeles**} *ss*.

On _____ before me, _____, Notary Public, personally appeared _____
_____,who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signatures(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.
I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.
WITNESS my hand and official seal.

_____
Signature