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MEDICAL AUTHORIZATION FORM FOR

FAMILY MEMBERS and/or CARE GIVERS

TO BRING MINOR CHILD FOR TREATMENT

I, _____, being the parent and/or legal guardian of _____ (hereinafter, my child/children, do hereby authorize _____ to seek and obtain medical care for my child/children in the event that my child/children need medical care.

My child has the following allergies: _____

I agree to be financially responsible for the cost of any medical care provided to my child/children under this authorization.

Date: _____

Signature of Parent (or Legal Guardian):_____

Printed Name: _____