

Authorization for Medical Treatment

Parents Name _____

Cell # _____, Work # _____, Home # _____

Address: _____

Children: _____, _____, _____

Birth Date: _____, _____, _____

Allergies, special instructions, etc.:

Emergency Contacts (Other than parents):

Pediatrician: _____ Phone: _____

Insurance (Name and number): _____ Phone: _____

We authorize _____ to give consent to surgical or medical treatment by a licensed physician or hospital for our children listed above when such treatment is deemed necessary by a physician and neither parent can be reached within a reasonable amount of time. Such consent may include anesthetics, medical treatment, tests, X-rays, pharmaceutical drugs, and surgery. It is understood that this authorization is given in advance of specific diagnosis or hospital care and must be used only for emergency treatment.

Parent Signature

Parent signature

*New participants are to provide a copy of this completed form to
Coop Coordinator and a copy for the Mom that is babysitting for you.*