Medical Treatment Authorization

Child's Name: _____

Date of Birth:_____

Medical Information

Primary Care Physician's Name: _____

Phone #: (____)_____

Medical Insurance Provider: _____ Policy #: _____

Preferred Hospital:_____

Allergies to Medications:

_____

Other pertinent medical information:

_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S) As custodian of the aforementioned minor, I grant my authorization and consent for a designated adult to administer general first aid treatment for minor injuries or illnesses. If the injury or illness is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a licensed medical professional or institution. I authorize the designated adult to exercise best judgment upon the advice of medical or emergency personnel.

Parent / Guardian Signature:_____

Printed Name: _____ Date: _____

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25 LINCOLN AVENUE SOMERS, NY (Physical address)
(914) 248-4020 LITTLEPEOPLESOMERS@GMAIL.COM