

MEDICAL AUTHORIZATION FORM

I. Family Information

Child's Name _____ Birth date _____

Parent's Name _____ Home phone _____

Work phone _____ Cell phone _____

Parent's Name _____ Home phone: _____

Work phone _____ Cell 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 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 Paul or Linda Adams 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 _____