Authorization for Medical Treatment of a Minor Child

This form has been filled out by me to designate temporary authority for my child's

babysitter _____ to obtain any necessary medical care for my child in the event I am unable to be reached for permission.

This care would encompass any emergent or urgent care required for the health and safety of my child. If I have not already called this office/clinic/hospital prior to the visit to give my explicit instructions, every attempt should be made to contact me before care is given unless it is a life-threatening emergency.

Please ask my babysitter for identification before authorizing any treatment for my child.

Child's full name: _____ Date of birth: _____

Home address: _____

Parent's name: _____ Phone #: _____

Babysitter's name: _____ Phone #: _____

Time period this authorization will be in effect: _____ to _____

Physician: _____ Phone #: _____

Specialist: _____ Phone #: _____

Dentist: _____ Phone #: _____

Child's medications: _____

Child's medical conditions: _____

Child's allergies: _____ Date of last tetanus booster: _____

Health insurance: _____ Phone: _____ Group #: _____

I acknowledge that I am responsible for all reasonable charges in connection with my child's treatment.

Signature: _____ Date: _____

Witness: _____ Date: _____