TEMPORARY MEDICAL TREATMENT AUTHORIZATION FOR MINORS

Effective Date

Place

1. Parties

This document is made on _____ (_____) by:

Parent / Legal Guardian

Individual

Full Legal Name

SSN / ID

Doc Series

Address

In favor of:

Caregiver

Individual

Full Legal Name

SSN / ID

Doc Series

Address

2. SUBJECT-MATTER SCHEDULE & SPECIFICATIONS

Child's Full Name & Date of Birth

Treatment Authorized

Allergies & Medical Conditions

Health Insurance Details

Authorization Valid Until

3. EXECUTION & SIGNATURES

Parent / Legal Guardian

Signature

Full Legal Name

Date