MEDICAL AUTHORIZATION FORM

PARENT / GUARDIAN

Full Name: _____

CHILD(REN)

Full Name: _____ Birth Date: _____

Full Name: _____ Birth Date: _____

Full Name: _____ Birth Date: _____

Full Name: _____ Birth Date: _____

Full Name: _____ Birth Date: _____

I, the undersigned Parent/Guardian, hereby give permission for _____ to authorize any and all medical treatment for the Child(ren) in the event of an emergency. This authorization shall remain in effect until _____ 20_____ (date).

Persons responsible should please note the following: (Please state aspects eg. allergies, tendency towards abnormal bleeding, epilepsy, etc.)

_____

_____

Present prescribed or other medication that is being administered:

_____

_____

Medical Aid / Insurer: _____

Group Number: _____

Policy Number: _____

I declare that I am the legal guardian of the Child(ren) and that I have legal authority to make the above authorizations for the Child(ren).

_____ _____ _____

PARENT/GUARDIAN name (print) SIGNED DATE