

## Authorization to Have My Child Medically Treated

\_\_\_\_\_ has permission to have my child treated for medical care.

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Printed Name of Parent or Legal Guardian:

\_\_\_\_\_

Signature of Parent or Legal Guardian:

\_\_\_\_\_

Date Signed: \_\_\_\_\_

Parent or Legal Guardian Phone Contact Information:

Home Phone: \_\_\_\_\_

Cell: \_\_\_\_\_