Medical Authorization for Minors

Minor's Legal Name	Birth Date	Allergies	Current Medications	Conditions	Physician	Dentist

In the event reasonable attempts to contact me have been unsuccessful I, _________________________, the parent or legal guardian of the above-named minor child(ren) do hereby authorize ____________________________ to consent to the administration of any treatment deemed necessary by the above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the aforesaid agent to give specific consent to any and all diagnosis, treatment, or hospital care which aforementioned physician in the exercise of his or her best judgment may deem advisable.

I hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to the above name agent upon completion of treatment.

These authorizations shall remain in effect until ____________________ __________, __________.
month day year

Signature of Parent or Legal Guardian ____ Date _______________________

Please copy parent's driver's license or other document which verifies identify and signature (sensitive information can be blacked out) and a copy of the insurance card for EACH child.