Stormont-Vail HealthCare

* 1 0 8 3 *

Parental Authorization for Medical Treatment

I hereby authorize _____ to approve medical treatment for
(Care Giver)

my child _____ whose date of birth is _____.
(Child's Name) (Month, Day, Year)

(Medical treatment may include diagnostic studies and interventions deemed necessary or advisable by the physician providing care to my child.)

This authorization is to cover a period of time from _____ to _____.
(Date) (Date)

Family Physician Or Pediatrician	Date of Last Tetanus Booster	Allergies
_____	_____	_____

Medications_____

Health Problems_____

Insurance Information_____
(Please attach a copy of your insurance card.)

Date_____ **Parent Signature**_____

_____
(Witness)

_____
(Address) (Telephone Number)

_____
(Witness)

_____
(Address) (Telephone Number)

This form should be left with the person caring for your child. The care giver should present it each time medical care is required. (**Note**: If you have more than one child, each child should have a separate authorization.)