



## GRANDPARENT MEDICAL PERMISSION TO TREAT A MINOR CHILD

Date \_\_\_\_\_

Regarding \_\_\_\_\_

\_\_\_\_\_  
(Give full Name of Child, Address, Date of Birth, Social Security Number)

As the parents/legal guardians of the above-named child, \_\_\_\_\_  
(Grandparents)  
has our permission to authorize emergency medical treatment.

Known allergies are: \_\_\_\_\_  
(List any known Allergies to Food, Medication, etc. or write "NONE")

This child's regular doctor is: \_\_\_\_\_

\_\_\_\_\_  
(Give Name, Complete Address, and Telephone Number)

This child is insured under medical policy \_\_\_\_\_

\_\_\_\_\_  
(Give Company, Policy Number, Listed Insured's Name and ID)

\_\_\_\_\_  
(Notarized Signature; Notary information attached)

\_\_\_\_\_  
(Notarized Signature; Notary information attached)

\_\_\_\_\_  
(Parent Name)

\_\_\_\_\_  
(Parent Name)

\_\_\_\_\_  
(Parent Address)

\_\_\_\_\_  
(Parent Address)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Work Phone)

\_\_\_\_\_  
(Home Phone)

\_\_\_\_\_  
(Home Phone)

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