



CARETAKER MEDICAL PERMISSION TO TREAT 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, _____
(Name of Responsible Adult)

has our permission to authorize emergency medical treatment to this child.

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)

(Signature)

(Signature)

(Parent Name)

(Parent Name)

(Parent Address)

(Parent Address)

(Work Phone)

(Work Phone)

(Home Phone)

(Home Phone)

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NOTE: This form **must** be notarized

(Notary Public)

(Notary Public)

(Date)

(Date)

(My Commission Expires)

(My Commission Expires)