

*Medical Treatment Authorization for a Minor*

I, \_\_\_\_\_ the undersigned, hereby grant \_\_\_\_\_  
(Name of the parent) (Name of the designated person)

, \_\_\_\_\_ the authority to obtain medical treatment for the following  
(relationship to child)

Child: (name/DOB) \_\_\_\_\_

The above-named child care provider(s) shall have the authorization to:

-obtain routine preventative care services.

-obtain medical treatment and procedures for the child as may be appropriate in emergency circumstances, including treatment by physicians, hospital, and clinic personnel, and other appropriate health care providers.

-obtain routine medical treatment from appropriate health care providers if symptoms of illness occur (e.g., fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.).

This grant of temporary authority shall begin on \_\_\_\_\_, and remain effective until termination by the undersigned or one year, whichever is shorter.

In case of an emergency, the child care provider(s) should first try to contact the parent(s). If the parent (s) cannot be reached, the child care provider should then contact the following person(s) in the order below:

1) Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Place of employment: \_\_\_\_\_

Work phone number: \_\_\_\_\_

Other phone number: \_\_\_\_\_

\_\_\_\_\_  
Signature of parent