MEDICAL TREATMENT OF A MINOR CHILD

This form has been filled out by me to designate temporary authority for my child's babysitter ______ to obtain any necessary medical care for my child in the event I am unable to be reached for permission.

This care would encompass any emergent or urgent care required for the health and safety of my child. If I have not already called this office/clinic/hospital prior to the visit to give my explicit instructions, every attempt should be made to contact me before care is given unless it is a life-threatening emergency.

Please ask my babysitter for identification before authorizing any treatment for my child.

Child's full name: ______ Date of birth: ______

Home address: ______

Parent's name: ______ Phone #: ______

Babysitter's name: ______ Phone #: ______

Time period this authorization will be in effect: ______ to ______

Physician: ______ Phone #: ______

Specialist: ______ Phone #: ______

Dentist: ______ Phone #: ______

Child's medications: ______

Child's medical conditions: ______

Child's allergies: ______ Date of last tetanus booster: ______

Health insurance: ______ Phone: ______ Group #: ______

I acknowledge that I am responsible for all reasonable charges in connection with my child's treatment.

Signature: ______ Date: ______

Witness: ______ Date: ______