Clear Form

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AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

Child
Full Legal Name:

Date of Birth: _____ Age: _____ Gender: Female

Doctor's Information
Doctor's Name:

Doctor's Address:

Doctor's Office Phone: _____ Doctor's Emergency Phone: _____
Medical Insurer/Health Plan: _____ Policy #: _____
Allergies to Medications:

Allergies (Other):

If applicable, please note the conditions for which the child is currently receiving treatment:

Note any other significant medical information:

Dentist's Information
Dentist's Name:

Dentist's Address:

Dentist's Office Phone: _____ Dentist's Emergency Phone: _____
Dentist's Insurer/Health Plan: _____ Policy #: _____

Parent(s)/Legal Guardian(s):

Parent #1:
Name:

Address:

Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information:

Parent #2:
Name:

Address:

Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information: