AUTHORIZATION TO TREAT MINOR CHILD

Please print all information

This form grants temporary authority for medical care at (name of clinic) _____ in the event of an illness or minor emergency, where the minor child is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This authorization is effective from (date) _____ to (date) _____

Minor Child Patient Information

Full Legal Name: _____

Billing Address: _____

Phone: _____

Date of Birth: _____ Gender: Female_____ Male_____

Insurance Information

Policy Holders Name: _____

Relationship to Patient: _____

Billing Address: _____

Date of Birth: _____

Social Security Number: _____

Name of Insurance: _____

Subscriber Number/ID: _____

Legal Parents or Guardians Information

Father: _____

Phone: _____

Mother: _____

Phone: _____

Legal Guardian: _____

Phone: _____

Emergency Contact: _____

Phone: _____

Parent / Legal Guardian Signature_____ Date_____