

# Medical Treatment Authorization Form

This form grants authority to a designated adult to arrange for medical care for a minor child in the absence of a parent or legal guardian.

Minor Child Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M or F ( Circle)

Home Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Allergies (Other): \_\_\_\_\_

Please note **all known** conditions for which the child is currently receiving treatment and any other significant medical information: \_\_\_\_\_

---

## AUTHORIZATION

I, \_\_\_\_\_, am the parent/legal guardian for of the minor child listed above. I grant authorization for \_\_\_\_\_ to do the following;  
(Adult 18 years or older)

\_\_\_\_\_ Take my child to a doctor's appointment at *Orange Doctors of Kids and Teens* and consent for care (Including treatment, medication, and immunizations)

\_\_\_\_\_ Call the doctor's office for triage

This authorization from is VALID during the following (please choose one);

\_\_\_\_\_ One time ONLY; Date: \_\_\_\_\_

\_\_\_\_\_ When I am not available

Parent / Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_