

AUTHORIZATION

FOR MEDICAL TREATMENT OF MINORS

THIS IS A LEGAL DOCUMENT

Names of Minors	Birthdates	Indicate allergies, special conditions and medication

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name(s)	Address	Phone

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence from:

_____ through _____
 Month / Day / Year Month / Day / Year

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent/Guardian		Parent/Guardian	
Signature		Signature	
Address Date		Address Date	
WITNESS		WITNESS	
Signature		Signature	
Address Date		Address Date	
Hospitalization Coverage For Above Named Minor(s):			
Insurance Company or Government Program		ID or Contract Number	
Family Physicians			
Name & Phone Number		Name & Phone Number	

BROUGHT TO YOU BY THOMPSONHEALTH

PHONE NUMBERS

HOW TO USE THIS FORM

This form is a LEGAL document. Leave it with your baby sitter or whoever takes care of your child. In the event of an emergency, the doctor, hospital, or emergency will require this signed form in order to treat your child.

Thompson Emergency Center: (716) 396-6600

Ambulance: _____

Fire Department: _____

Police: _____

Poison Control: 1-800-333-0542

Doctor: _____

Dentist: _____

We may be reached at: _____