Medical Authorization
For Person Other Than Parent/Guardian

I, _____, authorize _____
(Parent/Guardian Name) (Someone Other Than Parent/Guardian)

to take my son/daughter _____ for medical treatment if they
(Child's Name)
deem it necessary. I have provided them with medical insurance information, and understand

that I will be responsible for any balances not covered by my insurance.

_____
(Child's Name and Date of Birth)

_____ Is allergic to _____
(List Any Medications or Allergies)

_____Is **not** allergic to anything to my knowledge.

His/her Healthcare Provider is _____ at 731-285-4111.

_____
Parent/Guardian Signature

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