Medical Authorization Form

We, the undersigned, and parents of _____, hereby authorize _____ or _____, TEMPORARY GUARDIAN(S) of _____, to authorize any and all medical treatment for _____ they in their discretion see fit. This includes, but is not limited to, treatment to relieve pain. A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain in effect until _____(date).

Medical Insurance Company:_____

Medical Insurance ID or Group #:_____

Medical Insurance Company Phone #:_____

Doctor:_____

Doctor Phone #:_____

_____

Mother Signature Date

_____

Father Signature Date