



2450 Buckhorn Lane, Rhinelander, Wisconsin 54501

AUTHORIZATION FOR MINOR'S MEDICAL TREATMENT

Child

Full Legal Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Doctor's Information

Doctor's Name: _____

Doctor's Address: _____

Doctor's Office Phone: _____ Doctor's Emergency Phone: _____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

If applicable, please note the conditions for which the child is currently receiving treatment:

Note any other significant medical information:

Dentist's Information

Dentist's Name: _____

Dentist's Address: _____

Dentist's Office Phone: _____ Dentist's Emergency Phone: _____

Dentist's Insurer/Health Plan: _____ Policy #: _____

Parent(s)/Legal Guardian(s):

Parent #1:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____

Parent #2:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____

Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Pager: _____

Email: _____

Additional Contact Information: _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for _____ (hereafter "Supervising Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Supervising Adult to summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective commencing on the _____ day of _____, 20____ and expiring on the _____ day of _____, 20____.

Signed this _____ day of _____, 20 ____.

Parent #1's Signature

Parent #2's Signature