Medical Authorization Form

Child's Name: ___________________________________Age:________
Address:___________________City:_______________State:________
Physician:________________________Phone:_____________________
Insurance Co.:____________________Policy Number:_______________

Emergency Contact:

Name:________________
Address:_______________
City:_________________
State:________________
Zip:_________________

Phone Numbers:
Home ________________
Work ________________
Cell _________________
Beeper ________________

Past Medical History

(Check giving appropriate information)

___Asthma ___Sinusitis ___Bronchitis
___Kidney Trouble ___Heart Trouble ___Diabetes
___Dizziness ___Stomach Upset ___Hay Fever
___Epilepsy

Allergies:

Food_____________________________________
Penicillin or other drug (name)_________________
Insect Stings/Bites___________________________
Other_____________________________________

Previous operation or serious illnesses ____________________________
Any current medications you are taking (list) ______________________
____
____
____

Special diet: (Name) ____

Childhood Diseases:

___Chicken Pox ___Measles ___Mumps ___Whooping Cough ___Other

Immunizations:

___Tetanus ___Polio Booster ___Measles ___Mumps

Permission For Treatment

We/I ______________________________, father, mother or guardian of
(Parent/Guardian Name)
__________________________ hereby consent and authorize
(Child's Name)
__________________________ to give our/my consent and authorization to any health
(Chaperone's Name)
care provider to render any medical treatment deemed necessary for

_________________________________.
(Child's Name)

Signed ___________________________________ **Date**_____________

Signed___________________________________ **Date**_____________