



### AUTHORIZATION FOR TREATMENT OF A MINOR

<b>NAME OF CHILD</b>	
<b>DATE OF BIRTH</b>	
<b>MEDICATION ALLERGIES</b>	
<b>MEDICAL PROBLEM(S)</b>	

**I AUTHORIZE THE FOLLOWING PEOPLE TO BRING MY CHILD FOR EVALUATION AND TREATMENT IN THE OFFICE.**

<b>NAME</b>	
<b>ADDRESS</b>	
<b>FORM OF IDENTIFICATION</b>	
<b>RELATIONSHIP TO PATIENT</b>	

<b>NAME</b>	
<b>ADDRESS</b>	
<b>FORM OF IDENTIFICATION</b>	
<b>RELATIONSHIP TO PATIENT</b>	

**FOR EMERGENCIES, I CAN BE REACHED AT:**

<b>HOME PHONE NUMBER</b>	
<b>WORK PHONE NUMBER</b>	
<b>CELL PHONE NUMBER</b>	
<b>OTHER NUMBER</b>	

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME / RELATIONSHIP

\_\_\_\_\_  
SIGNATURE