PERMISSION TO TREAT WITHOUT PARENTS ACCOMPANYING CHILD

This form gives a medical facility/clinic permission to treat the below-referenced child without being accompanied by his/her parents, _____.

Child's Name _____ Date of Birth _____
Home Address _____ SSN _____

Father's Name _____ Home Phone _____
Home Address _____ Cell Phone _____

Employer's Name _____ Work Phone _____
Employer's Address _____

Mother's Name _____ Home Phone _____
Home Address _____ Cell Phone _____

Employer's Name _____ Work Phone _____
Employer's Address _____

Emergency Contact _____ Home Phone _____
Home Address _____ Cell Phone _____

Allergies _____
Special medications _____
Other Information _____
Pediatrician _____
Preferred Hospital _____

Name of insurance _____
Address _____
Policy Holder Name _____ SSN _____
Policy ID No. _____ Group No. _____

I hereby grant, _____, (relationship), (address), (phone), permission to authorize treatment for the above-listed child.

_____ _____
NAME Date Name Date

State of _____)
§
County of _____)

On this day _____ of _____, _____, before me, _____, a notary public, personally appeared, _____, proved on the basis of satisfactory evidence to be the person(s) whose name(s) (is/are)subscribed to this instrument, and acknowledged (he/she/they) executed the same. Witness my hand and official seal.

_____
NOTARY PUBLIC

SEAL