

CHILD MEDICAL CARE AUTHORIZATION

This is to acknowledge that _____

is authorized to obtain whatever medical attention is necessary should my child:

Child's Full Name

Social Security Number

Birthdate

be injured while in their custody.

Insurance Information:

Insurance Carrier _____

Policy Number _____

Group Number _____

Phone Number _____

Medical Information:

Doctor _____ Phone _____

Dentist _____ Phone _____

Known Allergies/Allergic Reactions

Signature

Relationship to Child

Date