

**PARENTAL AUTHORIZATION**  
**Consent to Medical Treatment for Child**

I, \_\_\_\_\_, of \_\_\_\_\_ (address),  
am the parent having legal custody of the child(ren) listed below. While being absent from my child(ren),  
from \_\_\_\_/\_\_\_\_/\_\_\_\_ until \_\_\_\_/\_\_\_\_/\_\_\_\_ I have entrusted his/her/their care to:  
Mo. Day Year Mo. Day Year

Name \_\_\_\_\_

Address \_\_\_\_\_

I authorize the adult(s) listed above to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the child(ren) under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the Commonwealth of Kentucky and/or state of Indiana.

CHILD'S NAME	DATE OF BIRTH	DATE OF LAST TETANUS SHOT	CURRENT MEDICATIONS
--------------	---------------	------------------------------	---------------------

1. \_\_\_\_\_

Allergies \_\_\_\_\_

Pertinent Medical History \_\_\_\_\_

2. \_\_\_\_\_

Allergies \_\_\_\_\_

Pertinent Medical History \_\_\_\_\_

3. \_\_\_\_\_

Allergies \_\_\_\_\_

Pertinent Medical History \_\_\_\_\_

4. \_\_\_\_\_

Allergies \_\_\_\_\_

Pertinent Medical History \_\_\_\_\_

Child's Doctor: Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Information: Policy Holder \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

This authorization shall only be effective during my absence on the dates set forth above. I agree to be financially responsible for all costs of medical treatment rendered to my child(ren).

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_