PERMISSION FOR MEDICAL TREATMENT

I/We _____ give my/our permission for
(Parents first and last names)

_____
(First and last names of those that can seek medical attention for children)

to seek medical attention at _____, and receive treatment for
(Name of Physician/Hospital/Etc)
my/our child/children:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: DOB:

Insurance Information:

Insurance Company: _____

Group#: _____ ID#: _____

Insurance Phone#: _____

Policy Holder:

Permission granted due to _____.

I/We can be contacted at (place) _____.

Phone #: ( ) Cell #: ( )

_____ _____
Parent(s)/Guardian(s) Signature Date