HEALTH CARE AUTHORIZATION

Date: ____________, 200___

Re: ____, age ____
____, age ____
____, age ____

TO HEALTH CARE PROVIDERS FOR OUR CHILD(REN):

We are temporarily entrusting our child(ren) to the care of:

____

____

____

Relationship:______________________

We can be reached at:

____
(   ) ________-____________

In our absence ________________________ may act for us in giving permission for both routine and emergency medical diagnosis, treatment and care.

Our child(ren)'s regular physician is:

____

____

____

KNOWN ALLERGIES OF OUR CHILD(REN):

Name:	Name:	Name:

This form is provided as a courtesy to our clients. Feel free to phone for more.
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SIGNIFICANT HEALTH HISTORY:

Name:	Name:	Name:

INFORMATION ON OUR HEALTH INSURANCE:

Company: ______________________ Policy #: __________

Telephone for Authorization: (   ) _______-______________.

SPECIAL INSTRUCTIONS:

Religious Affiliation: ___________________

Blood Transfusion:
Known donor only ☐

Applies only if checked

In an emergency, please try to contact us. In addition, please try to contact the following, if we cannot be reached:

Name:		
Relationship:		
Telephone:		

Thank you.

______________________________   ______________________________

Soc. Sec: - -   - -

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