Medical Information for Minor Children of:

Parents/Guardian

Name_____ Date_____

Address_____

Minor Children

Name	Birthdate	Allergies	Medical Problems/Medicines

Medical Insurance Information

Name of Insurance Company_____

Policy/Group ID_____

Policy Holder_____ Birthdate_____

	Name	Phone Number
Pediatrician		
Dentist		
Specialist		
Preferred Hospital		

I/We, being the parent(s) or legal guardian(s) of the above-named minor children hereby appoint:

_____

Name Address Phone Number

_____

Name Address Phone Number

to act on my/our behalf in authorizing unexpected medical care, dental care and hospitalization for the above-named minor(s) during the period of my/our absence from:

_____ through _____

month/day/year month/day/year

This document shall be presented to a physician, dentist or appropriate hospital representative at such times as unexpected medical care, dental care, and/or hospitalization may be required.

_____ _____

Parent/Guardian Name Parent/Guardian Name

_____ _____

Signature Signature

_____

Witness Name Signature Date

We, the parents/guardians can be reached in an emergency:

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____