



**MEDICAL TREATMENT  
AUTHORIZATION FORM  
2012-2013**

**To whom it may concern:** You may use this authorization form or a photostatic copy thereof as my permission for any medical treatment necessary for my child, \_\_\_\_\_

He/She is allergic to the following drugs: \_\_\_\_\_

And has been treated in the past year for the following illnesses: \_\_\_\_\_

My medical coverage is with (name and address of insurance company):

My Group Number is: \_\_\_\_\_

My Subscriber Number is: \_\_\_\_\_

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers: Day \_\_\_\_\_ Night \_\_\_\_\_

**NOTARIZATION.** Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_.

State of \_\_\_\_\_, County of \_\_\_\_\_

Notary Public: \_\_\_\_\_ My Commision Expires: \_\_\_\_\_

**FURTHER MEDICAL INFORMATION**

Is your child on medication right now? Please list \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

In case of emergency, please contact the following individuals:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Phone# \_\_\_\_\_

To what hospital do you want your child taken? \_\_\_\_\_