MEDICAL AUTHORIZATION FORM

I, _____, being the parent and/or legal guardian of _____ (hereinafter, my child(ren) do hereby authorize _____ to seek and obtain medical care for my child(ren) in the event that my child(ren) need(s) medical care.

My child has the following allergies: _____.(if applicable)

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this Authorization.

My health insurance carrier is _____ and my Policy or Certificate number is _____.

Date _____

Signature of Parent (or Legal Guardian) _____

Witness Signature _____