Authorization to Treat a Minor

| Minor's Full Name |
|-----------------------------|
| |
| Data of Diada |
| Date of Birth |
| |
| Age |
| |
| |
| Parent/Guardian Information |
| Parent/Guardian Name |
| |
| |
| Phone Number |
| |
| Email |
| Email |
| |
| Madical Information |
| Medical Information |
| Allergies |
| |
| |
| Current Medications |
| |
| |
| Medical Conditions |
| |
| |
| Physician's Name |
| Thysicianae Shame |
| |
| Physician's Phone Number |
| |

Authorization

| Authorization Statement | | | |
|---------------------------|--|--|---------------|
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| | | | |
| | | | |
| Parent/Guardian Signature | | | |
| | | | |
| | | | |
| Date | | | |
| Date | | | $\overline{}$ |
| | | | |