Medical Information for Minor Children

Parent/Guardian

Name_____ Date_____

Address_____

Minor Children

Name	DOB	Allergies	Medical Problems

Medical Insurance Information

Company Name_____ Policy/Contract # _____

Name	Phone	Name	Phone

Family Doctor_____

Sibling over 18 yrs_____

Grandparents_____

Aunts/Uncles_____

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

Name	Address	Phone
Name	Address	Phone

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

Month Day Year Through Month Day Year

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

Parent/Guardian	Parent/Guardian
Signature	Signature
Address	Address
Witness	Witness
Signature	Signature

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

Place_____ Telephone_____

_____ _____

_____ _____