MEDICAL TREATMENT AUTHORIZATION LETTER

TO WHOM IT MAY CONCERN:

As the parents of (name) _____, we authorize the bearer of this letter to approve medical treatment for our son/daughter if it is required and we are unable to be reached.

CONTACT INFORMATION

Home Phone:	_____	
	Mother	Father
Work Phone:	_____	_____
Mobile Phone:	_____	_____
Insurance Carrier & Policy Number	_____	

CHILD'S PERSONAL INFORMATION

Date of Birth:	_____
Blood Type:	_____
Known Allergies:	_____
Being Treated For These Chronic Conditions	_____
Pediatrician:	_____
Pediatrician Phone:	_____

Thank you,

_____

Mother's Signature

_____

Father's Signature

Subscribed and sworn to before me this _____ day of _____, 20____.

_____ Notary Public

_____ County, Texas