



## Authorization for Treatment of Minors

In absence of Parents and/or Guardians

DATE: \_\_\_\_\_

We/I \_\_\_\_\_  
Street Address, City, State and Zip Code

Home Telephone: \_\_\_\_\_ Give permission to: Aquia Harbour Preschool Staff  
(include area code) (must be 18 years of age or older)

to authorize emergency treatment at the nearest hospital to our/my child/children:

	Child's Full Name	Age	Date of Birth	Date of last DPT/Tetanus	Medicine Allergies
1.					
2.					
3.					

Date: From: \_\_\_\_\_ To: \_\_\_\_\_ (must be specific)

Child/children's Pediatrician/Family Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

List any known illness or chronic physical problem (asthma, epilepsy, diabetes, etc.) and routine medications given. (List per child)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone number where parent/guardian may be reached: \_\_\_\_\_  
(include area code)

Nearest Relative's Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
(other than parent/guardian) (include area code)

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employed By: \_\_\_\_\_

If possible, make a copy of subscriber's insurance card (front and back) and attach to form.  
 All commercial insurances must have signed form brought in to ensure billing for your convenience.

**AN EFFORT WILL BE MADE TO CONTACT PARENTS OR GURADIANS BEFORE IMPLEMENTATION OF THIS FORM.**

X \_\_\_\_\_  
Signature of Parent/Legal Guardian Date