

Better Kids Club

Medical Treatment Authorization & Consent for a Minor

We, _____ & _____ being the parents of _____; authorize _____ to seek, obtain & consent for any medical treatment by a licensed medical or health care professional that is deemed necessary while our child is attending a meeting or event. This authorization is for the time period when our child is in the care of the Better Kids Club. This authorization will last 1 year from the date it has been signed & must be renewed at the time that it becomes 1 year old.

Child's Information

Child's Full Name: _____

Address: _____

Date of Birth: _____ Age: _____ Sex: _____

Parent/Guardian's Information

Parent's Full Name: _____

Address: _____

Phone (h) : _____ Phone (c) :

Phone (w) : _____
Email: _____

Parent's Full Name: _____

Address: _____

Phone (h) : _____ Phone (c) :

Phone (w) : _____

Email: _____

Emergency Contact Persons' Information

Emergency Contact's Name:

_____ ¹

Relationship to Child: _____ Phone (h) :

Phone (c) : _____ Phone (w) :

Emergency Contact's Name:

Relationship to Child: _____ Phone (h) :

Phone (c) : _____ Phone (w) :

Child's Health Information

Health Conditions (ex. Asthma, diabetes):

Allergies (ex. Foods, medications):

Prescription Medications:

Date of last tetanus shot/booster:

Child's Medical Information

Physician Name/Facility:

Address: _____ Phone:

¹Authorization for Medical Consent/Treatment for a Minor

Dentist Name/Facility:

Address: _____ Phone: _____

Preferred Medical Facility:

Insurance Company:

Policy Number: _____ Policy Holder's Name:

Signature of Parent or Guardian(s)

print

sign date

print

sign date²

²Authorization for Medical Consent/Treatment for a Minor