Community Eye Care of Indiana

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Minor Medical Treatment Authorization and Consent

I, _____[Full Legal Name of Parent/Guardian], being the [parent/legal guardian] of _____[Child's Full Name] authorize _____[Full Name of Caregiver] to seek, obtain and consent to medical care and treatment for _____[Child's Full Name] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of _____[Full Name of Caregiver], my child's _____[Relationship to Child (e.g. grandmother, grandfather, aunt, uncle, nanny, baby-sitter, family friend, teacher)] and is effective _____ until _____.

Child's Information
Child's Full Name: _____
Address: _____
Date of Birth: _____ Age: _____

Parent/Guardian's Information

Parent's/Guardian's Name 1: _____
Address: _____
Phone Number (H): _____Phone Number (C): _____

Parent's/Guardian's Name 2: _____
Address: _____
Phone Number (H): _____Phone Number (C): _____

Child's Health Information

Health Conditions (e.g. Asthma, Diabetes): _____
Allergies (e.g. to Medications, Food): _____
Prescription Medications: _____
Date of Last Tetanus Injection/Booster: _____

Child's Medical Care and Insurance Information

Physician/Pediatrician: _____Phone Number: _____
Preferred Medical Facility: _____
Insurance Company: _____
Policy/Group Number: _____Policy Holder: _____

SIGNATURE OF PARENT/GUARDIAN

Signature _____Date _____
Print Name _____

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