ST JOHN PROVIDENCE HEALTH SYSTEM

MR# _____

Authorization for Medical Treatment of Minors

Names of Minors	Birthdates	Identify Allergies or special conditions

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

Name	Address	Phone
Name	Address	Phone

To act in my/our behalf in authorizing medical treatment, dental treatment or hospitalization for the above named minor(s) during the period of my/our absence, from:

Month	Day	Year		Month	Day	Year
			through			

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as medical treatment, dental treatment or if hospitalization may be required. If notarized valid for one year.

Parent/Guardian		Parent/Guardian	
Signature	Date	Signature	Date

Address

Witness (Notary Public)

Signature	Date	Stamp/Seal
Address		

Health Insurance Information for above named minor(s):

	ID or Contract Number

Family Physicians:

Name & Phone Number	Name & Phone Number