

BEST KIDS CARE

Authorization For Minors Medical Care

I _____ the parent or legal guardian of the minor(s) listed below:

1. _____ BIRTH DATE _____
2. _____ BIRTH DATE _____
3. _____ BIRTH DATE _____
4. _____ BIRTH DATE _____
5. _____ BIRTH DATE _____

Do hereby authorize medical treatment by Best Kids Care.

Please understand that if there is a person who is not named below accompanying my child to the doctor they must have a written and signed document by the parent or legal guardian that allows the accompanying adult to receive care and information for and about my child.

Name of adult individual(s) who can bring the child in for the medical treatment:

- _____
- _____
- _____

Name of adult individual(s) who are not allowed to receive information. Please also bring this to the attention of the receptionist.

- _____
- _____

Telephone number(s) where the parent or legal guardian can be reached.

Phone No.: () _____

Phone No.: () _____

X _____

Date: _____

Parent Signature and Relationship to Minor