

# Parental Permission

## TO SEEK HEALTHCARE FOR MY CHILD(REN)

*Bring this form to the clinic or hospital when seeking treatment.*

I, \_\_\_\_\_, am the parent of (list each child's first and last name)

\_\_\_\_\_  
\_\_\_\_\_.

In my absence, \_\_\_\_\_, has my permission to seek medical care for my child(ren).

The **primary care physician** for my child(ren) is \_\_\_\_\_ phone \_\_\_\_\_.

Insurance provider \_\_\_\_\_ Contact info \_\_\_\_\_.

*List each child's name, any medications, chronic illnesses, and allergies.*

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

Medications \_\_\_\_\_

Chronic Illnesses \_\_\_\_\_

Allergies \_\_\_\_\_

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

Medications \_\_\_\_\_

Chronic Illnesses \_\_\_\_\_

Allergies \_\_\_\_\_

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

Medications \_\_\_\_\_

Chronic Illnesses \_\_\_\_\_

Allergies \_\_\_\_\_

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

Medications \_\_\_\_\_

Chronic Illnesses \_\_\_\_\_

Allergies \_\_\_\_\_

**Please contact me** on my cell phone at (\_\_\_\_) \_\_\_\_-\_\_\_\_.

Parent's name printed \_\_\_\_\_

Parent's name signed \_\_\_\_\_

Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective through date \_\_\_\_/\_\_\_\_/\_\_\_\_ (not to exceed one year)

11-279

