authorization

for emergency treatment of minors

M. Djafari, M.D.
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Name of minor | Age | Birthdate

Address

Allergies	Medications	Last Tetanus Shot

Medical history, if pertinent:

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

Name | Address | Phone

Name | Address | Phone

To act in my/our behalf in authorizing emergency medical, dental, surgical care and hospitalization for the above-named minor during the period of my/our absence.

Month | Day | Year — Month | Day | Year

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, surgical care or hospitalization may be required.

Signature of Parent/Guardian

Address

State | Zip | Phone | Date

Witness | Date

Signature of Parent/Guardian

Address

State | Zip | Phone | Date

Witness | Date

Hospitalization Insurance
Family Physicians or choice of specialists

Identification or Contract Number
Phone Number