Medical Treatment Authorization Letter

Date: _____

To Whom It May Concern:

Our minor child(ren) named below, will be traveling with and under the temporary guardianship of:

Name(s): _____

Relationship: _____

Address: _____

During the Dates of: _____

In case of medical emergency during our absence, please try to reach the children's parents/legal guardians first at these numbers:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

In the event that none of the legal guardians noted above can be reached by phone during a medical emergency, we authorize (Names):

_____
to make any medical decisions necessary to ensure proper treatment. We will assume all expenses related to the medical care for our child(ren).

The minor children are covered by a medical insurance policy issued by:

_____ Insurance Company.

Child's Name: _____ Policy ID: _____
Child's Name: _____ Policy ID: _____
Child's Name: _____ Policy ID: _____
Child's Name: _____ Policy ID: _____

Insurance Company Phone: _____

Minors' Physician Contact Info: _____

_____ _____
Parent/Legal Guardian Signature Parent/Legal Guardian Signature