Siskiyou Community Health Center

AUTHORIZATION TO TREAT

Please instruct your child care provider or other family member who regularly cares for a minor child to bring this form with them to our office when you can't personally bring your child (under 15 years of age) to give us specific permission to treat your child. That permission must come from the child's parents or legal guardians. It cannot come from sibling, grandparents, etc.

EMERGENCY CARE AUTHORIZATION

Name of Child and Date of Birth: **Please note: if completing a medical release for multiple children, please use a separate form for each child.*

Name: _____ Date of Birth _____

Child Care Provider/Family Member Information

Name (First and Last): _____

Phone Number: _____ Relationship to Patient: _____

I, the undersigned, have given permission for the above mentioned child care provider or family member to seek medical treatment for my child(ren), including immunizations, in my absence on the following dates:

Beginning Date: _____ End Date: _____

I understand that these services may result in charges billed to my insurance and/or myself.

Parent/Guardian Contact Information

Home Phone: _____ Cell Phone: _____

Address: _____

Insurance Carrier: _____ Policy #: _____

_____ _____

Parent Signature Date Printed Name

_____ _____

Witness Signature Date Printed Name