FREMONT COUNTY DEPARTMENT OF
PUBLIC HEALTH & ENVIRONMENT
201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

Minor Medical Treatment Authorization Form

Name of Minor: _____ Date of Birth: _____ Gender: M F
Address: _____ City: _____ State: _____ Zip: _____

Parent's name: _____ Phone: _____

Physician's Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____
Allergies (Other): _____

Note any significant medical information:
_____
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

NOTE: If there are any special parental custodial relationships (such as custody with one parent only, legal custody/ guardianship with non- parent, etc.), please explain in the space below with your signature, printed name, and phone number at which you can be contacted.
_____
_____
_____

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for _____ (hereafter "Designated Adult") to seek medical evaluation and treatment for the minor listed above. If there is an injury or illness that is life threatening during the visit and in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.
It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Signed this _____day of_____, 20_____.

Parent / Legal Guardian Signature: _____Printed Name: _____

Witness Signature: _____Printed Name: _____