AUTHORIZATION LETTER

To Whom It May Concern:

As the parents of (list each childs name and date of birth)
_____
_____

We authorize _____
(name and date of birth)
to approve medical treatment for our son/daughter if it is required and we are unable to be reached. Our best contact phone number is _____.
Our son/daughter is allergic to: _____
He/she is being treated for the following chronic conditions:
_____
_____

Thank you.
Signed

_____
Sign Print (relationship to patient)

_____
Sign Print (relationship to patient)

_____
Date