MI Elite Authorization for Medical Treatment

Parent(s)/Guardian(s)

Address City State Zip

Home Phone Work/Cell

_____ _____

Medical/Health Insurance Co. Insurance Policy No.

_____ _____

Emergency contact person(s) Relationship to minor

Allergies/allergic reactions of child

Medications being taken by child

Other information regarding my child's health that a doctor should know

I am the parents or legal guardians of the above named minor child. I understand that, in the event that medical treatment is required, every effort will be made to contact the above named parent/guardian. However, in the event that I cannot be reached, I give permission to provide the medical treatment necessary for my child's well being. I accept full financial responsibility for said medical treatment.

Parent/Guardian Signature Date