GRANDPARENT MEDICAL PERMISSION TO TREAT MINOR CHILD

Date _____

To whom it may concern:

Regarding _____

_____

(Give full Name of Child, Address, Date of Birth, Social Security Number)

As the parents (or custodial parent) of the above-named child,

_____

(Grandparents)

have our permission to authorize emergency medical treatment to this child.

Known allergies are: _____

(List any known Allergies to Food, Medication, etc. or write "NONE")

This child's regular doctor is: _____

_____

(Give Name, Complete Address, and Telephone Number)

This child is insured under medical policy _____

_____

(Give Company, Policy Number, Listed Insured's Name and ID)

_____	_____
(Signature)	(Signature)
_____	_____
(Parent Name)	(Parent Name)
_____	_____
(Parent Address)	(Parent Address)
_____	_____
_____	_____
(Work Phone)	(Work Phone)
_____	_____
(Home Phone)	(Home Phone)
_____	_____
(Notary Public)	(Notary Public)
_____	_____
(Date)	(Date)
_____	_____
(My Commission Expires)	(My Commission Expires)

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