# STEPPARENT 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 of the above-named child, _____

(Name of Responsible Adult)

has 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) |

NOTE: This letter **must** be notarized.