

***MEDICAL TREATMENT AUTHORIZATION FOR A MINOR***

I, \_\_\_\_\_, hereby grant Montana Performance Gym, of 2490 Gabel Rd, Billings Mt 59102, the authority to obtain medical treatment for the following child(ren):

Name of Child: \_\_\_\_\_

Birthdate: \_\_\_\_\_

The above care provider(s) are authorized to:

- obtain medical treatment and procedures for the child(ren) as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate health care providers.

- obtain routine medical treatment from appropriate health care providers if symptoms of illness occur (e.g., fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.).

- administer medications as follows:

Name of Child: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Amount to be Given: \_\_\_\_\_

Time to be Given: \_\_\_\_\_

This grant of temporary authority shall begin on June 01, 2023, and shall remain effective until terminated by the undersigned.

Dated: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Address: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_