Kaukauna Clinic, SC
"Your partners in Family Health Care"

Kaukauna Clinic, S.C.

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AUTHORIZATION TO PROVIDE EMERGENCY MEDICAL CARE FOR A MINOR IN THE ABSENCE OF PARENT/GUARDIAN

In my absence, I do hereby authorize the medical treatment, by a licensed physician/nurse practitioner/physician assistant, in the event of a medical emergency, to the following minor:

Name of minor: _____

Date(s) for when authorization is valid: _____

Signed: _____

Printed name: _____

Relationship to minor: _____

INSURANCE INFORMATION:

Name of insurance company: _____

Address to send claim to: _____

Member ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Relationship to minor: _____

Effective date of coverage: _____