

**G.G.S.A.**  
**Authorization for Medical Treatment**  
**of a Minor**

NAME OF MINOR	BIRTH DATE	IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

I / We, being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint:

NAME	ADDRESS	PHONE
NAME	ADDRESS	PHONE

To act in my / our behalf in authorizing unexpected medical care and hospitalization for the above named minor during the period of my / our absence.

This document shall be presented to a physician or appropriate hospital representative at such time as unexpected medical or surgical care or hospitalization may be required.

**HOSPITALIZATION COVERAGE FOR ABOVE NAMED MINOR:**

INSURANCE COMPANY OR GOVERNMENT PROGRAM	ID OR CONTRACT NUMBER
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**FAMILY PHYSICIAN:**

NAME AND PHONE NUMBER	NAME AND PHONE NUMBER
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<b>PARENT / GUARDIAN SIGNATURE</b>
ADDRESS
DATE

<b>PARENT / GUARDIAN SIGNATURE</b>
ADDRESS
DATE

State of Texas  
 County of Dallas

Subscribed and sworn to before me, a Notary Public in and for Dallas County, Texas this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.