Authorization of Emergency Treatment

Child's Information

Child's Name: ____

Child's Date of Birth: ____

Child's Allergies (if any) : ______________________________________

Child's Doctor: __________________________ Telephone Number: _____________________

Family's Doctor: _________________________ Telephone Number: _____________________

Medicines Child is Taking: ______________________________________

Last Tetanus Shot: ____

Outstanding Medical History (example: Diabetes, Heart Disease, etc.):

____

Insurance Information

Insurance Company: ____

Identification/Policy Number: ___________________________________

Subscribers Name: ____

Subscriber's Place of Employment/Phone Number: _____________________

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I, _______________________________, give permission for _____________________________
(Name of Parent) (Name of Provider)

to obtain profession medical care for my child if an emergency occurs and I cannot be reached immediately. I agree to accept the financial responsibility for all medical expenses incurred.

____ ____
Date **Signature of Parent or Guardian**

All parents and guardians are responsible for maintaining this consent form as it cannot be maintained by the hospital.