Authorization for 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: _____

Subscriber's Name: _____

Subscriber's Place of Employment /Phone Number: _____

_____

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I, _____, give permission for _____
(Name of Parent) (Name of Provider)

to obtain professional 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.