Authorization for Emergency Treatment

The _____ (Child Care Provider) has my permission, in an emergency when I, or the legal guardian or designated emergency contact cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well being of my child. I agree to accept the financial responsibility for all medical expenses incurred.

_____ (Child's Name)

Child's Date of Birth: _____

Child's Allergies (if any) _____

Child's Dr. _____ Telephone Number _____

Family's Dr._____ Telephone Number _____

Medicines Child is Taking: _____

Last Tetanus Shot: _____

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

_____

<u>Insurance Information:</u>
Insurance Company:_____

Identification/Policy Number: _____

Subscriber's Name: _____

Subscriber's Place of Employment and Phone Number: _____

_____

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

Date Signature of Parent and Guardian