

AUTHORIZATION FOR EMERGENCY TREATMENT

I, _____, here by authorize any and all medical attention deemed necessary for my child, _____, in the event of an accident, injury, sickness, etc., under the direction of the bearer of this form, until such time as I may be contacted. This release is effective until revoked by me and I hereby assume the responsibility for payment of such treatment

MEDICAL INFORMATION:

Child's Dr.: _____ Telephone No: _____

Family Dr.: _____ Telephone No: _____

Child's Allergies (if any): _____

Date of last Tetanus Shot: _____

Medicines Child is taking: _____

Outstanding Medical History (i.e. Diabetes, Heart Diseases, etc.): _____

INSURANCE INFORMATION:

Insurance Company: _____ Policy _____

Subscriber's Name: _____

Subscriber's Place of Employment: _____

PARENT/GUARDIAN INFORMATION:

Name: _____

Address: _____

Phone No. (Home) _____ (Work, M) _____ (Work, F) _____

SIGNATURE(S) OF PARENT/GUARDIAN

Date: _____

Date: _____