AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

PLEASE TYPE OR PRINT

If my child _____, date of birth _____,

If my child _____, date of birth _____,

If my child _____, date of birth _____,

month/day/year

becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Health Provider: _____ Telephone No.: _____

M.D./N.P.

(Area Code)

Address: _____

I give permission to _____, located at

Name of Facility or Caretaker

_____, to take my child(ren) for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child(ren), which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child(ren): _____

Policy Number: _____ Medicaid Number: _____

Coverage: _____

Child(ren)'s Known Allergies or Health Conditions:

Yes _____ No _____

If yes, explain here: _____

_____

_____

Home Address: _____

Street

City/State

Zip Code

Area Code/Telephone No.: _____ _____ _____

Home Business Pager/Cell Phone

Signature: _____

Relationship to Child(ren): _____Date: _____

month/day/year