Emergency Medical Authorization

Purpose: to allow parents to authorize medical treatment for their children (up to and including 17 years of age) when a parent cannot be reached.

Name of minor:____

Name of Parents or legal Guardians:____

I, _________________________, hereby consent to the rendering of Emergency Department care and such medical treatment as the attending physician or others of the hospital's medical

staff consider to be necessary for my child, ______________________________________, on

and including the dates ________________through _____________, 20__.

Medical Information

Allergies:____

Date of last Tetanus shot:___________________ Date of Birth:____________________________

Home Address:____

Home Phone:______________________________ Pager/Cell Phone:_________________________

Insurance Co. and Address:____

Policy Number:____________________________ Group Number:___________________________

Name of Policy Holder:____

Occupation:______________________________ Employer:_________________________________

Other Emergency phone numbers:____

Family Physician:__________________________ Phone:__________________________________

Dentist:________________________________ Phone:____________________________________

Medical Specialist:________________________ Phone:__________________________________

Any other pertinent medical information? ____

____

____

Signature of Parent/Legal Guardian Date

Witness_________________________________Witness___________________________________