



**EMERGENCY MEDICAL CONSENT FORM**

<b>Child's Name</b>		Male / Female
<b>Date of Birth</b>		
<b>Chronic Illnesses or Conditions</b>		
<b>Allergies</b>		
<b>Current Medications</b>		
<b>Date of last Tetanus Shot</b>		
<b>Medical Information</b>		

**Parent Information**

	Name	Telephone	Employer	Work Phone
<b>Mother</b>				
<i>Step-Father</i>				
<b>Father</b>				
<i>Step-Mother</i>				
<b>Other Emergency Contact</b>				

**Medical Providers**

	Name	Telephone
<b>Physician</b>		
<b>Dentist</b>		
<b>Medical Specialist</b>		
<b>Hospital</b>		

**Medical Insurance Information** *(optional)*

<i>Medical Insurance Provider</i>	<i>Member #</i>	<i>Group #</i>	<i>Telephone</i>

*In the event your child needs emergency medical care and you are not available to provide formal consent to medical authorities, care may become unnecessarily delayed. In the event of a medical emergency, this form should be provided to responding medical personnel and accompany your child to the hospital/clinic so that medical treatment can be rendered.*

*In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent to (1) the administration of any treatment deemed necessary by the above name doctor(s), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover any major surgery unless the medical opinions of two other licensed physicians or dentists, concurring for such surgery, are obtained prior to the performance of such surgery.*

**Parent/Guardian:** \_\_\_\_\_ **Signature date:** \_\_\_\_\_