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: ____

Names of Parents or Legal Guardians: _______________________________________

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

consider to be necessary for my child, ____, on

and including the dates ______________ through _____________, 200___.

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: ____

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Family Physician: _________________________ Phone: ________________________________

Dentist: _________________________________ Phone: ________________________________

Medical Specialist: ________________________ Phone: ________________________________

Any other pertinent medical information? _______________________________________

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Signature of Parent/Legal Guardian Date

Witness: ________________________________ Witness: ______________________________