Child's Emergency Medical Authorization

CHILD'S MEDICALLY DIAGNOSED ALLERGIES OR CHRONIC CONDITIONS ETC.

CHILD'S MEDICAL NUMBER	
OTHER INSURANCE ☐ YES ☐ NO	IF YES, COMPANY
INSURANCE NUMBER	
The Parent/Guardian authorizes immediate medical and consents to the hospitalization of and/or the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to his/her child or ward if an emergency occurs when he/she cannot be located immediately.	
SIGNATURE OF PARENT OR GUARDIAN	DATE
NOTE: THIS FORM IS TO BE KEPT BY THE PROVIDER AND IS TO BE TAKEN TO THE DOCTOR OR TREATMENT FACILITY IN CASE OF EMERGENCY.	

NAME OF CHILD	BIRTHDATE
NAME OF PARENT(S) OR GUARDIAN	
ADDRESS	
CITY, STATE, ZIP	PHONE
MOTHER'S EMPLOYMENT	
ADDRESS	
CITY, STATE, ZIP	PHONE
FATHER'S EMPLOYMENT	
ADDRESS	
CITY, STATE, ZIP	PHONE
GUARDIAN'S EMPLOYMENT	
ADDRESS	
CITY, STATE, ZIP	PHONE
CHILD'S PHYSICIAN OR CLINIC	
ADDRESS	
CITY, STATE, ZIP	PHONE