Emergency Medical Authorization Form

Child's Name:_____

Address:_____ Telephone_____

Clinic:_____Doctor:_____Phone:_____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name_____Phone_____

Father's Name_____Phone_____

Please list at least two persons to be called in case parents cannot be reached:

Name:_____Relationship to child_____

Address_____ Phone_____

Name:_____Relationship to child_____

Address_____ Phone_____

Any known allergies:_____

Last tetanus shot:_____

Signature of parent/Guardian Date

Any special instructions: