CHILD’S EMERGENCY MEDICAL AUTHORIZATION

Name of Child_______________________________ Birthdate_____________________________
Name of Parent(s) or Guardian____
Home Address____
Phone__________________ Mother Cell Phone _______________Father Cell Phone ________________
Place of Mother’s Employment__________________________________Phone______________
Address____
Place of Father’s Employment___________________________________Phone______________
Address____

The parent(s)/guardian authorizes____
(Name of Licensed Provider)
to obtain immediate medical care and consents to the hospitalization of, 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. It is also understood that this agreement covers only those situations that are true emergencies and only when he/she cannot be reached. Otherwise, he/she expects to be notified immediately.

1. I/We will be responsible for payment of medical care expenses. ________________________
2. Medical treatment costs are covered by:
   a. Blue Cross/Blue Shield Policy Number______________________________________
   b. Medicaid Coverage Number____
   c. Other Medical insurance____
      Name of Insurance Company____
      Policy Number____
      No Insurance____

Child’s Physician or clinic attended____

Child’s Allergies (if any)____
Child’s Doctor____Phone__________________
Family Doctor____Phone__________________
Medicines child is taking____
Last Tetanus Shot____
Outstanding Medical History (i.e., Diabetes, Heart Disease, etc.) __________________________
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Date____________________________ __________________________________
(Signature of Parent(s)/Guardian)

This form is to be kept by the licensed care provider and is to be taken to the doctor or treatment facility in case of emergency.