Authorization for Medical Treatment

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child ______________________, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants.

Child's Name: ________________________________ Grade: ____________

Date of Birth:__________________________ Home Phone _____________

Emergency Phone Numbers:

Father at Work: _________________________ Cell or pager: ____________

Mother at Work: ________________________ Cell or pager: ____________

Other: _________________________________

Name of Medical Insurance Company: ____

Policy Number: __________________________ Group Number: ___________

Name of Family Doctor: __________________ Phone: __________________

Date of Last DTP or Tetanus: ______________

Check if child has any of the following. Please explain any positive answers.

___ Asthma ___ Rheumatic Fever ___ Scarlet Fever
___ Bladder Problems ___ Heart Trouble ___ Contact Lenses
___ Diabetes ___ ADHD ___Epilepsy/Seizures

Explanations: ____

Is you child on any continuous medication? ____ Specify: ________________________

Does you child have any allergies? ___ Yes ___ No
If yes, please explain: ____

Is there any other medical information that you feel we should know about your child?
____

Sworn to and subscribed before me

this _______ day of __________, ___________ ____________________________________

____ Parent/ Guardian Signature, Date

Notary Signature; Exp. Date: ________________