EMERGENCY MEDICAL AUTHORIZATION

In the event that reasonable attempts to contact me at (phone number) _____ or (other parent) _____ at (phone number) _____ have been unsuccessful, I hereby give my consent for the administration of any treatment for (child's name) _____

The child's doctor's name is _____

The child's dentist's name is _____

The preferred hospital is _____

The child's birthdate is _____

The child's last tetanus shot was (date) _____

Facts concerning the medical history (allergies, medications taken, and any physical impairments) to which a physician should be alerted are:

Date: _____

Parent or Legal Guardian: _____

Parent or Legal Guardian: _____

Home Address: _____

City, State, Zip: _____

Phone Number: _____

INSURANCE INFORMATION:

Member Name: _____

Member Number: _____

Group Number: _____

Carrier Name: _____

Insured SSN: _____