MEDICAL EMERGENCY FORM

Birth Date _____

Age _____

_____
Child's Name (Last Name, First Name, Middle Initial) Phone Number

_____
Street Address City Zip

_____
Birth Date Age

_____
Father's Name Business Phone

_____
Mother's Name Business Phone

_____
Pediatrician's Name Phone Number

_____
Dentist's Name Phone Number

_____
Relative/Friend's Name Phone Number

In the event reasonable attempts to contact me at _____ or _____
Phone Number Other Parent/Guardian

at _____ have been unsuccessful, I hereby give my consent for:
Phone Number

(1) The administration of any treatment deemed necessary by Dr. _____
Preferred Physician
or Dr. _____, or, in the event the designated preferred practitioner is
Preferred Dentist
not available, by another licensed physician or dentist; and

(2) the transfer of the child to _____ or any hospital reasonably
Preferred Hospital
accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____
_____
_____
_____
_____
Signature of Parent or Guardian Date