Emergency Authorization For Medical Treatment

NAME OF CHILD:____

Name of parent: ____

Social Security #: ____

Address: ____

City: ____________ State: ____________ Zip: ____________

Telephone: Home: (   ) ________________

Work: (   ) ________________

Cell: (   ) ________________

I authorize emergency medical treatment for my child in the event that I cannot be contacted immediately.

My child's physician or medical service provider is:

Name: ____

Address: ____

City: ____________ State: ______ Zip: ____________

Telephone: (   ) ________________

Health insurance provider: ____________________________

Policy number: ____________________________

____
Parent Name

____
Date

____
Parent Signature