

# CONSENT FOR EMERGENCY MEDICAL TREATMENT

(I) (We), the undersigned parents, agency representative or legal guardian of \_\_\_\_\_  
Name of Child  
\_\_\_\_\_, a minor, do hereby authorize \_\_\_\_\_  
Name of Child Care Provider  
of \_\_\_\_\_  
Name of Facility to call a physician, dentist or emergency medical  
personnel, to consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital  
care which is deemed advisable by such personnel and rendered by such personnel.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital  
care being required, but is given to provide authority and power on the part of our child care provider listed above  
to give specific consent to any and all such diagnosis, treatment of hospital care which the medical personnel, in  
the exercise of their best judgment, may deem advisable.

It is understood that a conscientious effort must be made to notify (me) (us) before such action is taken. It  
is further understood that we release the child care provider presenting this form of all liabilities connected with the  
transportation, diagnosis, treatment, hospital care and expenses necessary for the treatment of (my) (our) child.

_____ Date	_____ Father or Legal Guardian
_____ Date	_____ Mother or Legal Guardian
_____ Date	_____ Witness

## MEDICAL INFORMATION

Child's Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Address \_\_\_\_\_

Emergency Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_ Allergies? \_\_\_\_\_

If yes, list allergies here (be specific) \_\_\_\_\_  
\_\_\_\_\_

Any other medical conditions or chronic illnesses? (Be Specific) \_\_\_\_\_  
\_\_\_\_\_

List any medications currently taken regularly \_\_\_\_\_

Out-of-State Contact \_\_\_\_\_

Relationship and Telephone Number