

Emergency Medical Consent Form

my permission to obtain emergency medical treatment for my child, when I cannot be reached			
or if a delay in reaching my child wou	uld be dangerous for him/her.		
Mother/Guardian's Name			
Home Phone	Work Phone		
Cell Phone			
E-mail Address:			
Father/Guardian's Name			
Home Phone	Work Phone		
Cell Phone			
E-mail Address:			
Medical Information			
My insurance provider is			
My child's medical record number is			
Preferred hospital/treatment center			

My child is taking the following medications	5	
My child has the following allergies		
I understand that I assume all financial resp injuries sustained by my child while he/she i		tment or
Signature of Parent or Guardian	Date	
Signature of Parent or Guardian	 Date	