Parental Emergency Medical Consent Form

The **Parental Emergency Medical Consent** form authorizes the provision of emergency treatment for the child named below in the event of illness or injury while under the program's authority. The form must be presented for treatment when the parent(s)/guardian(s) cannot be reached.

CHILD'S NAME:		**BIRTH DATE:**
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES:		
1. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACT PERSON(S)		
1. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER

PERSONS AUTHORIZED TO PICK UP CHILD	**ADDRESS**	**PHONE NUMBER**
1.		
2.		

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the program? Please provide legal documentation.

Name	Name

PHYSICIAN NAME	**DENTIST NAME**
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
KNOWN ALLERGIES	DATE OF LAST TETANUS
PRESENT MEDICATION	
INSURANCE COMPANY	POLICY HOLDER ID

I give consent for the administration of treatments deemed necessary by the healthcare professionals identified above or other healthcare professionals when they are unavailable. I agree to pay all costs and fees as secured and authorized under this consent for up to one year beyond the date of signature.

Signature of Parent/Guardian Date

Signature of Parent/Guardian Date

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