AUTHORIZATION TO TREAT A MEDICAL EMERGENCY

CHILD'S NAME_____DATE_____

I AUTHORIZE A LICENSED PHYSICIAN TO EVALUATE MY CHILD IN THE EVENT HE/SHE IS TAKEN ILL AND/OR IS IN AN ACCIDENT. SHOULD TREATMENT BE DEEMED NECESSARY BY THE PHYSICIAN, AND IN THE EVENT I CANNOT BE REACHED AFTER EVERY REASONABLE EFFORT HAS BEEN MADE, I ALSO AUTHORIZE SUCH TREATMENT IN ADVANCE.
IN SUCH EVENT THE DIRECTOR, OR HER STAFF MAY SIGN THE HOSPITAL AUTHORIZATION FORMS FOR TREATMENT.
A COPY OF THIS AUTHORIZATION MAY BE CONSIDERED AS VALID IN LIEU OF THE ORIGINAL. PERMISSION IS GRANTED FOR MY CHILD TO BE TRANSPORTED TO THE HOSPITAL, FOR AN EMERGENCY ROOM TREATMENT, OR X-RAYS.
I WILL BE RESPONSIBLE FOR PAYMENT.

PARENT/GUARDIAN_____**DATE**_____

EMERGENCY NUMBER_____

ALLERGIES_____

DATE OF LAST TETANUS_____

HEALTH INSURANCE_____

INSURED PERSON_____

GROUP NUMBER_____