

**2010 Emergency Medical Authorization Form**

**PLEASE PRINT**

**Parents Name (Last, First)**

**Children (list all)/ Age**

**Street Address**

**City/ State/ Zip**

**Numbers to call in the event of an emergency:**

<i>Name</i>	<i>Phone #</i>	<i>Alternate Phone #</i>
Mother		

Father

Babysitter

Alternate Emergency Contact

In the event reasonable attempts to contact parents/guardians are unsuccessful, I hereby give my consent for:

1) The administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (phone number) \_\_\_\_\_ or Dr. \_\_\_\_\_ (phone number) \_\_\_\_\_ or in the event the designated practioner is not available, by another licensed physician or dentist.

2) The transfer of the child to \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Identify facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

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Signature of Parent of Guardian

Date

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