

Emergency Medical Authorization Form

Child's Name: _____

Address: _____ Telephone: _____

Clinic: _____ Doctor: _____ Phone: _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

Name of Relative or Childcare Provider: _____

Relationship: _____ Phone: _____

Address: _____

Please list at least two persons to be called in case parents cannot be reached:

Name: _____ Relationship to child: _____

Address: _____ Phone: _____

Name: _____ Relationship to child: _____

Address: _____ Phone: _____

Any known allergies to Medication: _____

Last tetanus shot: _____

Signature of Parent/Guardian

Date

Special Instructions: