# AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

**PLEASE TYPE OR PRINT**

If my child _____, date of birth _____,
If my child _____, date of birth _____,
If my child _____, date of birth _____,
month/day/year

becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Health Provider: _____ Telephone No.: _____
M.D./N.P. (Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caretaker

_____, to take my child(ren) for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child(ren), which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child(ren): _____

Policy Number: _____ Medicaid Number: _____

Coverage: _____

Child(ren)'s Known Allergies or Health Conditions: Yes _____ No _____

If yes, explain here: _____
_____
_____

Home Address: _____
Street City/State Zip Code

Area Code/Telephone No.: _____ _____ _____
Home Business Pager/Cell Phone

Signature: _____

Relationship to Child(ren): _____ Date: _____
month/day/year