Emergency Medical Authorization Form

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

Child's Name: _____

Address: _____**Phone:** (____)_____

Clinic: _____ **Doctor:** _____**Phone:** (____)_____

Known allergies to medication: _____

Last tetanus shot: _____ **Other medical conditions:**_____

Residential Parent or Guardian:

Mother's Name: _____ **Daytime phone:** (_____)_____

Father's Name: _____ **Daytime phone:** (_____)_____

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

Name: _____ **Relationship to Child:** _____

Address: _____ **Daytime phone:** (____)_____

Name: _____ **Relationship to Child:** _____

Address: _____ **Daytime phone:** (____)_____

_____ _____

Signature of Parent/Guardian **Date**

Special Instructions: