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: