Emergency Medical Authorization

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

Name of Church/Organization:____

Name: ____M / F (circle one) Date of Birth:_____________
Address: ____
City, State, Zip: ____ Home Phone: _____________________

Residential Parent or Guardian:
Mother: ____ Phone: ______________________________
Father: ____ Phone: ______________________________
Guardian: ____Phone: ______________________________
Other Contact: ____ Phone: ______________________________
Relationship to youth: ____

Doctor: ____ Phone: ______________________________
Dentist: ____ Phone: ______________________________
Medical Specialist: ____ Phone: ______________________________
Local Hospital: ____ Phone: ______________________________
Health/Medical Insurance Carrier:_____________________________Policy #:______________________________

Allergies: ____
Medications: ____
Last Tetanus Shot: ___/___/___

PART I OR II MUST BE COMPLETED:

PART I TO GRANT CONSENT FOR MEDICAL TREATMENT

In the event reasonable attempts to contact me or other parent or guardian have been unsuccessful, I hereby give my consent to (1) the administration of any treatment deemed necessary by the listed doctor, dentist, or medical specialist, or in the event the designated preferred practitioner is not available, by a licensed physician or dentist; and (2) the transfer of the child to the above 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 or such surgery.

Facts concerning the child's medical history to which a physician should be alerted:

____
____
____

Signature of parent or guardian: ____ Date: _____________

PART II REFUSAL TO CONSENT (Do not complete if you completed PART I)

I do not give consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the authorities to take the following actions:

____
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Signature of parent or guardian: ____ Date: _____________