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:	Name of Church/Organization:	
Address:  City, State, Zip:  Home Phone:  Residential Parent or Guardian:  Mother:  Phone:  Guardian:  Other Contact:  Phone:  Relationship to youth:  Doctor:  Phone:  Dentist:  Phone:  Dentist:  Phone:  Dentist:  Phone:  Dentist:  Phone:  Health/Medical Specialist:  Phone:  Health/Medical Insurance Carrier:  Policy #:  Allergies:  Medications:  Last Tetanus Shot:  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:  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:	Name:	M / F (circle one) Date of Birth:
City, State, Zip:	Address:	
Mother:	City, State, Zip:	Home Phone:
Father:	Residential Parent or Guardian:	
Father:	Mother:	Phone:
Chardrain: Phone: Phone: Phone: Relationship to youth: Phone: Pho	Father:	Phone:
Other Contact:	Guardian:	Phone:
Doctor:	Other Contact:	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:  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:	Relationship to youth:	
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:  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:	Doctor:	Phone:
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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:	Medical Specialist:	Phone:
Health/Medical Insurance Carrier:	Local Hospital:	Phone:
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