

Authorization for Medical Treatment and Transportation of a Child

Child's full name: _____

Home Address: _____

Home Telephone number: _____

Additional phone numbers: _____

Please complete the following information:

Date of last tetanus shot: _____

Allergies to medications: _____

Chronic medical problems: _____

Current medications: _____

Child's doctor(s): _____

Current immunization status: _____

Name, address and phone numbers (including cell phones) of adult relative to be notified in case of an extreme emergency:

I, _____ hereby give my permission to _____
(parent/guardian) (name of person in charge of child)

to obtain medical or surgical care for my child whose name is _____

and whose birth date is _____, should the need arise. It is understood that a conscientious effort will be made to locate me before action is taken. If this is not possible, treatment deemed necessary by the physician(s) may be taken.

I further consent to transportation of the above named child to the nearest or most appropriate medical facility.

Date: _____

Parent/Guardian

Date: _____

Witness