AUTHORIZATION FOR TREATMENT

To Whom It May Concern:

This document is to be used for AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT for the child(ren) listed below:

Name: _____ Sex: _____ Birthdate: _____

Name: _____ Sex: _____ Birthdate: _____

Name: _____ Sex: _____ Birthdate: _____

Name: _____ Sex: _____ Birthdate: _____

Address: _____ Zip: _____

Home Phone: _____ Emergency Phone: _____

Parents (legal guardians) Names: _____

Address (if different): _____

Insurance Company and Policy Number: _____

Doctor: _____ Phone: _____

Allergies or past or present medical problems? _____ NO _____ Yes
(if YES, please explain on back)

THIS DOCUMENT GIVES CONSENT TO ANY HOSPITAL OR EMERGENCY TREATMENT CENTER, DOCTOR OR QUALIFIED EMPLOYEES OF THE SAME TO ADMINISTER NECESSARY TREATMENT AND CARE. IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN, SELECTED BY THE ADULT LEADER IN CHARGE, TO HOSPITALIZE, SECURE PROPER ANESTESIA, OR TO ORDER INJECTION OR SURGERY FOR MY CHILD.

Parent/Guardian Signature _____ Date _____

Witness: _____ Date _____