

**PARENTAL EMERGENCY MEDICAL CONSENT**  
**This form must be presented upon admission for treatment.**

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (phone number) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor \_\_\_\_\_ (physician) at \_\_\_\_\_ (phone number) or Doctor \_\_\_\_\_ (dentist) at \_\_\_\_\_ or in the event the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to \_\_\_\_\_ (preferred hospital).

**1. Parents/Guardians/Custodians with Whom the Child Resides:**

• Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

• Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

**2. Persons to Contact In Case of Emergency if Parents Are Unavailable, and are Authorized to Pick Up Child:**

• Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

• Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Email Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

**3. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?**

• Name \_\_\_\_\_  
 • Name \_\_\_\_\_

**4. Information:**

Physician name _____	Dentist name _____
Street address _____	Street address _____
City, State _____	City, State _____
Phone # _____	Phone # _____

Date of Last Tetanus \_\_\_\_\_ Known Allergies \_\_\_\_\_

Present Medication \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Holder's I.D. \_\_\_\_\_

This consent **will be in effect for one year** beginning (date) \_\_\_\_\_.

Signature Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Signature Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_