Consent for Emergency Treatment

Child's Name _____ Birth date _____

EMERGENCY NOTIFICATION:
If a parent/guardian cannot be reached, we must have the name and number of friends or relatives who would be available:

1. Name _____ Relationship to Child _____
   Phone _____ Address _____
2. Name _____ Relationship to Child _____
   Phone _____ Address _____
3. Name _____ Relationship to child _____
   Phone _____ Address _____

Our procedure for handling emergencies of accidents is as follows:

1. We will make every effort to contact a parent/guardian, then the emergency numbers listed in the event a parent cannot be reached.
2. We will seek out the closest medical attention available.

Child's Primary Physician

Name _____ Phone _____

Address _____

Child's Dentist

Name _____ Phone _____

Address _____

Insurance Company _____ Group Number _____

I hereby authorize any medical hospital physician to administer treatment to my child, named above, arising from illness or accident. I understand that if my insurance does not cover the cost, I will be responsible for paying.

Parent/Guardian Signature _____ Date _____

My child is 18 or older and is their own guardian: ☐ YES ☐ NO
This consent is valid for one year.