

MEDICAL EMERGENCY AUTHORIZATION FORM

I/we _____, being the parent or legal guardian of _____ give my/our consent for emergency medical, surgical treatment and/or calling of an ambulance should my/our child's condition require it in my/our absence. I /we understand that in such a case, reasonable attempts would first be made to contact me/us, time and conditions permitting. I/we assume all financial responsibility.

I/we impose no specific prohibitions regarding treatment unless stated below: (If none, put none)

My/our child has the following medical condition(s) _____

Parent/Guardian

Parent/Guardian

According to The Department of Social Services this form must be notarized and dated.

Notary

Parent signature acknowledged – Date: _____

Commission expires: _____ **Name:** _____

Emergency Contact

Mother Home # _____ **Work #** _____ **Cell or Pager #** _____

Father Home # _____ **Work #** _____ **Cell or Pager #** _____

Doctor _____ **Phone #** _____