

## EMERGENCY TREATMENT AUTHORIZATION

In case of an emergency, treatment and/or care of \_\_\_\_\_  
is authorized at any hospital.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

If I cannot be reached during an emergency, I authorize you to contact the following to act on my behalf:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Specify  Parent OR  Guardian

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### MEDICAL HISTORY:

1. Does the child have any known allergies? Yes  No  , if yes please list below:

\_\_\_\_\_

2. Is the child taking any prescription medication? Yes  No  , if yes please list below:

\_\_\_\_\_

3. Does the child have any history of respiratory illness? Yes  No  , if yes please list below:

\_\_\_\_\_

4. Please list any existing medical conditions:

\_\_\_\_\_

5. Date of last tetanus shot: \_\_\_\_\_

If you wish that a family doctor be contacted in case of emergency, please indicate the name and telephone number: \_\_\_\_\_