

Emergency Treatment Form

TO WHOM IT MAY CONCERN:

As a parent and /or guardian of _____, a minor, I herewith authorize treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Parent/Guardian _____

Address _____ Phone _____

Family Physician _____ Phone _____

Dates during which release is granted: From _____ To _____

Specific medical allergies, chronic illness or other medical conditions staff should be aware of:

Other contact in case of emergency:

Name _____ Relationship _____ Phone _____

This release form is completed and signed of my own free will with sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature _____ Date _____

Father, Mother or Legal Guardian