CHILD'S EMERGENCY CONSENT FORM

Child's full legal name: ____

Child's preferred name(s): ____

Birthday: _______________ Gender: ______________

Who has legal custody?: ____

Relationship to child: ____________________ Phone: ______________

Address: ____

Mother's Name: ____

Address: ____

Home Phone: ___________________ Work Phone: _________________

Cell Phone: ____________________ Pager: _____________________

Father's Name: ____

Address: ____

Home Phone: ___________________ Work Phone: _________________

Cell Phone: ____________________ Pager: _____________________

Child's Health Care Number: ____

Child's physician: ____

Address: ____

Phone: _______________________ Fax: ______________________

Does your child need any prescribed medication or therapy?

YES ___ NO ___

If YES, then please describe:

What it is: ____

What it is for: ____

When is it administered: __________________________________

How is it administered: ___________________________________

Any side effects: ____

Does your child have any of the following:

Allergies: ____

Disabilities/ Special Medical Needs? : ___________________________

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In case of an emergency, who do we contact? : _________________________

Phone: ________________ Cell: ______________ Pager: _____________

If this person cannot be reached, then who? : __________________________

Phone: ________________ Cell: ______________ Pager: _____________

Date of enrolment: ________________________

AUTHORIZATION TO PROVIDE EMERGENCY CARE

This consent shall remain effective until _______________, of the year ____________.

I (we) the undersigned parents/guardians of __________________________________, a legal minor, do hereby authorise and consent to any examination, anaesthetic, medical or surgical diagnosis and procedure under the general or special supervision of any member of the medical emergency room staff, or licensed dentists. I (we) understand this authorisation is given in advance of any diagnosis or treatment and provides any aforementioned medical personnel authority and power to render care in the exercise of best judgement. It is understood that effort shall be made to contact the undersigned prior to rendering treatment, but such treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: ____

Signature of parent(s) / guardian(s):

____ Date: ___________________

Please print name _________________________________

Signature of parent(s) / guardian(s):

____ Date: ___________________

Please print name _________________________________