



# EMERGENCY CARE CONSENT FORM

In the event of a medical or traumatic emergency, I hereby grant permission for my child

**Child's Name:** \_\_\_\_\_

To obtain necessary treatment at \_\_\_\_\_.

Date of last Tetanus shot: \_\_\_\_\_.

Any allergies, medications, or medical information we should be aware of: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**I understand that I am responsible for the cost of treatment.**

\_\_\_\_\_ Phone Days ( ) \_\_\_\_\_

Signature of Parent or Guardian

\_\_\_\_\_ Phone Evenings ( ) \_\_\_\_\_

Address

Child's Birthdate \_\_\_\_\_ Parents' First Name(s) \_\_\_\_\_

Name of Insured Person \_\_\_\_\_ Insurance \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_

Date \_\_\_\_\_ Valid through \_\_\_\_\_



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