

# AUTHORIZATION FOR EMERGENCY TREATMENT

*Please print clearly*

I, \_\_\_\_\_, hereby authorize any licensed (MD) physician to render emergency or urgent medical treatment, which in his/her judgment may be deemed necessary to protect life and prevent serious detriment to health in the care of \_\_\_\_\_ (name of child or dependent) from September 1, 2008 through June 30, 2009.

Daytime Telephone Number \_\_\_\_\_ Evening Telephone Number \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

Allergies (if any) \_\_\_\_\_

Food Allergies (if any) \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Telephone Number \_\_\_\_\_

Family Doctor \_\_\_\_\_ Telephone Number \_\_\_\_\_

Medicines Child is taking \_\_\_\_\_

Last Tetanus Shot \_\_\_\_\_

Outstanding Medical History (ex. Diabetes, Heart Disease, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

## **INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_

Identification/Policy Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Place of Employment \_\_\_\_\_

This consent form is applicable to the dates noted only, and will be maintained by The Church of the Good Shepherd staff person(s) accompanying the above named child or dependent at that time.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_