Emergency Medical Treatment Authorization

I,_____ give _____,
(Parent/Guardian name) (Care provider's name)

and their employees permission to obtain emergency medical/dental treatment for my

child _____
(Child's name)

Child's Physician: _____ Phone: _____

Pysician's address: _____

Child's Care Care Number:_____

Parent's Address: _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____

_____ _____
Parent Signature Date

_____ _____
Care Provider signature Date