CONSENT FOR EMERGENCY MEDICAL TREATMENT

This form is intended to acknowledge consent for the child(ren) named below to receive emergency medical treatment at the hospital named below or other necessary institution.

Name of child_____Age_____

Pediatrician_____Phone_____

Health Insurance#_____-

Hospital_____

Known (life-threatening) allergies_____

May child be given ( ) aspirin () children's tylenol Dosage_____

Non-Emergency treatments: May child be treated with:

() Sunblock () insect repellant () Homeopathic medicines

Comments:_____

_____

_____

Parent signature_____Date_____

Parent signature_____Date_____