

Consent for Emergency Medical Treatment

As primary caregiver/parent/guardian my signature below gives permission for emergency medical treatment for:

Name: _____
(First, Middle, Last Name)

Date of Birth: _____

Address: _____

Phone: _____

Signature (primary caregiver/parent/guardian) _____ Date _____
(Valid for one year after date listed above unless otherwise noted.)

INSURANCE
INFORMATION: _____

Disabilities: _____

Medical
Condition: _____

Known
Allergies: _____

Medication: _____

Special
Instructions: _____
