



EMERGENCY TREATMENT RELEASE

I hereby give my consent for a licensed physician, dentist, emergency medical personnel, or hospital to provide emergency medical services to my child, _____, at the request of the person bearing this consent form. I understand that emergency medical services include, but are not limited to, transportation to and from any healthcare facilities and/or any medical professional to provide treatment, order injections, hospitalize, give anesthesia or perform surgery. I understand that this authorization is given prior to any need for medical care, but given to avoid unnecessary delay in emergency treatment. I will presume that reasonable effort has been made to contact me. The care referenced in this Release may be given under any circumstances necessary to preserve the life, limb, or well being of my child named above.

My child has the following known allergies (if none, please write NONE): _____

My child has the following known medical conditions (if none, please write NONE): _____

My child takes the following medications - include over-the-counter medications and vitamins (if none, please write NONE): _____

I understand that I am and shall remain financially responsible for any medical treatment provided to my child pursuant to this Release.

Signature of Parent/Guardian

Date

Name of Parent/Guardian (print)

Name of Primary Insurer

Policy Number

Name of Responsible Party

Member Identification Number

Child's Pediatrician/Primary Care Physician

Phone Number of Physician