

# EMERGENCY CARE CONSENT FORM

In the event of a medical or traumatic emergency, I hereby grant permission for my child

**Child's Name:**

---

To obtain necessary treatment at

---

Date of last Tetanus shot: \_\_\_\_\_

Any allergies, medications, or medical information we should be aware of:

---

Doctor Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**I understand that I am responsible for the cost of treatment.**

**Parent (s) Name(s)** \_\_\_\_\_

**Signature of Parent or Guardian (s)**

---

---

**Date** \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

**Address** \_\_\_\_\_

Child's Birthdate \_\_\_\_\_

Name of Insured Person \_\_\_\_\_

Insurance \_\_\_\_\_

Place of Employment \_\_\_\_\_