ABSENT PARENT PERMIT FOR EMERGENCY MEDICAL/SURGICAL CARE

In the event that my child (listed below) may require medical and/or surgical care when I am unable to be reached, I hereby authorize evaluation, treatment, and anesthetics, as deemed necessary by the ______________________________ Hospital, and attending physician for the following child:

Child's Name ______________________________ DOB: _______________ Age: __________

Allergies: ____

Present Medication: ____

Medical History: ____

Surgical History: ____

Other Pertinent Information: ____

Family Physician: __________________________________ Phone Number: _______________

Family Medical Insurance Co: _______________________________ Policy #: ______________

Person(s) able to provide authorizing signature when parent(s) are unable to be reached:

Name: ____ DOB: ___________________

Address: ____

Home Phone #: _________________________ Work Phone #: ___________________________

Relationship to the child: ____

This form is provided for parent's convenience in their absense. Authorization is valid beginning ________________________ and ending __________________________.

Authorizations must be renewed after one year from the date documented below:

Date of Permission Signature: _________________________.

Parent's Signature: ____

Address: ____

Home Phone #: _______________________ Work Phone #: ____________________________

Mom's Cell #: ________________________ Dad's Cell #: _____________________________

AUTHORIZATION IS TO BE LEFT WITH THE RESPONSIBLE ADULT AND PRESENTED TO THE HOSPITAL STAFF AT THE TIME EMERGENCY MEDICAL AND/OR SURGICAL CARE IS REQUIRED.