Emergency Contact and Medical Information for a Child

Child's Name

Date of Birth

Parent's/Guardian's Name

Parent's/Guardian's Name

Home Phone

Work Phone

Home Phone

Work Phone

Address

Address (If not Same)

City, ST ZIP Code

City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact

Secondary Emergency Contact

Home Phone

Work Phone

Home Phone

Work Phone

Address

Address

City, ST ZIP Code

City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

Insurance Company

Policy Number

Allergies/Special Health Considerations

As the parent/legal guardian I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such license technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures, and an x-ray treatment of the above-named minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I accept full financial responsibility for any such treatment. I also give permission for any transportation required to a medical facility and assume full financial responsibility for said transportation.

Parent's/Guardian's Signature

Date