MERCYONE℠

Emergency treatment authorization **for minors**

Your child cannot receive medical treatment without your consent. To ensure immediate medical attention for your child in your absence, complete this information and keep with your child's caregiver.

Treatment will begin if a physician feels immediate care is necessary to prevent death or serious injury.

Child's name _____ Date of birth _____

Child's primary address _____

City/State/ZIP _____

MEDICAL HISTORY:

Child's primary physician _____

Physician address _____ Physician phone _____

Date of last tetanus _____ Allergies _____

Medications (and dosage) _____

Chronic illness or medical problems _____

Additional information or instructions _____

PARENT/GUARDIAN INFORMATION

Parent/guardian name _____

Primary phone _____ Alternate phone _____

Address _____

City/State/ZIP _____

Insurance company _____ Policy/Group # _____

AUTHORIZATION

As the parent/guardian, I authorize a physician to give medical treatment in the event of an emergency. This authorization is granted only after a reasonable effort has been made to reach me.

_____ _____

Parent/guardian signature Date

_____ _____ _____

Witness name (please print) Witness signature Date

Relationship to child _____