Authorization for Treatment of a Minor

In the event of an emergency medical situation relating to my minor children as listed below, and in the event that I am unavailable, I hereby give my consent to St. Alexius Medical Center or any other hospital to administer whatever emergency medical care deemed appropriate by emergency medical staff, until I can be contacted.

Name of Child:		Date of Birth:		Allergies:	
Medication Child is Currently Using:				Date of last Tetanus:	
Past Medical History:					

Name of Parent or Guardian:					
Address of Parent or Guardian:					
Home Phone:				Office Phone:	
Name of Spouse:				Office Phone:	
Doctor Name:				Phone:	
Also Notify:				Relationship:	
Home Phone:		Cell Phone:		Office Phone:	

Signature of Parent or Guardian: ____________________________________ Date: