

MEDICAL CONSENT FORM

In case of emergency, _____ has my
consent to authorize medical care for my child(ren) listed below:

_____	_____
_____	_____
_____	_____

Our family physician is:	
His/her address is:	
His/her telephone # is:	
Our hospital preference is	
Allergies:	
Contact me immediately at:	

If unable to contact me, please call:

_____ <i>Name</i>	_____ <i>Telephone</i>
_____ <i>Name</i>	_____ <i>Telephone</i>

Signed by

Name: _____ Telephone: _____
Address: _____ Date: _____