

Emergency Medical Treatment Consent Form

Child's Name \_\_\_\_\_

In the event that I cannot be reached. I authorized Grace to transport my child to the nearest hospital emergency room, at the discretion of the emergency team, and I hereby grant my consent for the hospital and its medical staff to provide my child with any emergency medical treatment which the physician deems necessary. If my child is participating in an off-site activity he or she will be transported to and cared for at the nearest hospital. I agree to accept all financial responsibility for all medical expenses incurred.

Child's Birthday \_\_\_\_\_ Child's current weight \_\_\_\_\_

List all know special conditions or allergies

Describe all past serious illness or hospitalizations and their dates

List all medications currently being taken by child

Health Insurance/Name of Policy Holder \_\_\_\_\_

Insurance Company \_\_\_\_\_

Employer Name \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

I hereby certify that the information supplied above is to the best of my knowledge, complete and accurate.

\_\_\_\_\_  
Parent Signature/Date

\_\_\_\_\_  
Parent Signature/Date