



AUTHORIZATION TO PROVIDE EMERGENCY MEDICAL CARE

Date: _____

I hereby authorize any licensed physician to provide any necessary medical services to my child, _____, in a medical emergency, and I agree to promptly pay said physician his fee for rendering services.

Signature: _____

The following condition should be noted in rendering medical services:

My child is covered with the following **MEDICAL INSURANCE**:

Insurance Company: _____

Policy Number: _____ Type of Policy: _____

Policy Holder: _____

IN CASE OF EMERGENCY, NOTIFY

Name: _____ Relationship: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): _____ Office: _____

Cell: _____