



EMERGENCY MEDICAL AUTHORIZATION

To Whom It May Concern:

We, the parents of (Child's Name) \_\_\_\_\_, authorize the bearer of this letter to approve emergency medical treatment for our child if it is required and we are unable to be contacted. We understand that every effort will be made to contact us at the numbers below and that these attempts will continue at frequent intervals until we are contacted.

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's Home Telephone: \_\_\_\_\_ Father's Home Telephone: \_\_\_\_\_

Mother's Work Telephone: \_\_\_\_\_ Father's Work Telephone: \_\_\_\_\_

Mother's Mobile Telephone: \_\_\_\_\_ Father's Mobile Telephone: \_\_\_\_\_

Alternate - Name & Number: \_\_\_\_\_

Alternate - Name & Number: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Child is allergic to: \_\_\_\_\_

Chronic conditions under treatment: \_\_\_\_\_

Other health information: \_\_\_\_\_

Child's physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_ Telephone: \_\_\_\_\_

Policy / Group Number: \_\_\_\_\_

Thank you,

Signed,

\_\_\_\_\_

Parent or Legal Guardian

Subscribed and sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_ Notary Public

\_\_\_\_\_ County, Texas