

ABSENT PARENT PERMIT FOR EMERGENCY MEDICAL/SURGICAL CARE

In the event that my child (listed below) may require medical and/or surgical care when I am unable to be reached, I hereby authorize evaluation, treatment, and anesthetics, as deemed necessary by the _____ Hospital, and attending physician for the following child:

Child's Name: _____ DOB: _____ Age: _____

Allergies: _____ Date of last Tetanus Shot: _____

Present Medication: _____

Medical History: _____

Surgical History: _____

Other Pertinent Information: _____

Family Physician: _____ Phone Number: _____

Family Medical Insurance Co.: _____ Policy No.: _____

Person(s) able to provide authorizing signature when parent(s) are unable to be reached

Name: _____ DOB: _____

Address _____ City/State _____ Zip Code _____

Home Phone: _____ Work Phone: _____

Relationship to the child: daycare provider

This form is provided for parent's convenience in their absence. Authorization is valid beginning _____ and ending _____.

Authorizations must be renewed after one year from the date documented below:

Date of Permission Signature: _____

Parent's Signature: _____

Address _____ City/State _____ Zip Code _____

Home Phone: _____ Work Phone: _____

AUTHORIZATION IS TO BE LEFT WITH THE RESPONSIBLE ADULT AND PRESENT TO THE HOSPITAL STAFF AT THE TIME EMERGENCY MEDICAL AND/OR SURGICAL CARE IS REQUIRED.