FISHER | TITUS MEDICAL CENTER
Simply Smarter Care

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EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured when parents or guardians cannot be reached.

I am a parent, guardian, or the person with whom the minor(s) lives who is listed below.

If any minor is ill or injured and you cannot reach me, try and reach the other persons in the order named, each whom hereby are authorized in my absence to consent for treatment to be given to the child.

If, after a reasonable attempt, you cannot reach me or the other persons listed below for permission, I hereby give my consent for any treatment deemed necessary by the physician or dentist listed below, or if one listed below is not available, by another licensed physicians or dentist.

Dr.: _____ *(Preferred Physician)*

Dr.: _____ *(Preferred Dentist)*

This authorization does not cover major surgery unless the opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

_____

Children:

Name ***Date of Birth***

_____

_____

_____

Other Adults to Be Contacted:

Name ***Address*** ***Telephone***

_____

_____

_____

Signature of Parent or Guardian: _____ **Date:** _____

Address: _____ Phone: _____