

Emergency Medical Consent for Minor

I, , am the parent/legal guardian of , born on .

In the event of a medical emergency, I authorize any licensed physician, hospital, or medical provider to administer emergency medical treatment as deemed necessary for my child.

Parent/Guardian Contact Information

Phone Number:

Address:

Minor's Medical Information

Allergies:

Current Medications:

Other Medical Conditions:

Insurance Information

Insurance Company:

Policy Number:

Consent Validity

This consent is valid from: to:

Parent/Guardian Signature: _____

Date: _____