

Emergency Authorization Form for Medical Emergency Treatment

Date: _____

As parent or legal guardian of _____, a minor, I hereby give my consent to St. Anthony's Preschool/Daycare and or Schenectady UPK to seek medical treatment in the event of an emergency. I hereby give my consent to ELLIS HOSPITAL/ST. CLARE'S HOSPITAL to provide any treatment and conduct any tests which are required necessary treatment to the above named minor in my absence.

CHILDS BIRTH DATE: _____

PEDIATRICIAN/FAMILY M.D. NAME AND PHONE: _____

ALLERGIES: _____

DENTIST: NAME: _____ PHONE: _____

LAST TETANUS: _____ RELIGION: _____

In the event of any emergency in which the above named physicians are not available, I give my consent to provide treatment by any appropriate ELLIS HOSPITAL/ST. CLARE'S HOSPITAL Medical/Dental staff member on duty.

OTHER PERTINENT MEDICAL INFORMATION: _____

TYPE OF INSURANCE COVERAGE:

ID NUMBER: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____

BILLING ADDRESS: _____

PARENT/LEGAL GUARDIAN EMPLOYER: _____

EMPLOYER ADDRESS: _____

PARENT/LEGAL GUARDIAN ADDRESS/PHONE: PHONE: _____

ADDRESS: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN:

NOTES: