



Emergency Medical Permission

Child's Full Name _____

Street Address _____

City _____ State _____ Zip _____

Parent/Guardian _____ Daytime Phone # _____

Parent/Guardian _____ Daytime Phone # _____

Other Contact _____ Daytime Phone # _____

Other Contact _____ Daytime Phone # _____

Health Insurance Information: _____

You have my permission to transport (Child's Full Name) _____

_____ to _____ Hospital and

authorize treatment by the doctor on call.

Signature _____ Date _____

Signature _____ Date _____