



EMERGENCY TREATMENT PERMISSION SLIP

We, the parents of _____, give our permission for emergency treatment of our child, _____ from (date) ___/___/___ to ___/___/___, or indefinitely.

Birth Date of Child: ___/___/___.

Allergies: _____

Medication child is taking: _____

Date of Last Tetanus: ___/___/___.

Pertinent Medical History: _____

Dentist Preferred: _____

Our family Physician is: _____
(if admission is required) _____

We may be reached at: _____

Nearest Relative: _____

Relationship

Phone No.

Witness

Signature of Parent

Witness

___/___/___
Date

Insurance Information:

Employer Insurance Paid Thru

Contract No.

Or Medicaid No.

ID No.

Address of Insurance Co.