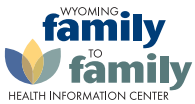
Authorization for Emergency Medical Treatment



Child's name: _____

Date of birth: _____

Date of last tetanus shot: _____

Current medications:

Allergies to medications:

Chronic medical conditions:

In the event of an emergency requiring medical treatment/aid due to illness or injury while in the care of, _____ **, I** _____ **authorize medical or surgical care from a healthcare facility, physician, or dentist for my child. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the health care facility/physician/dentist may be taken. I further consent to transportation of the above-named child to the nearest or most appropriate medical facility.**

Insurance company that oversees the above-named child: _____

Address: _____

Phone: _____

Name of policy holder: _____ **Policy number:** _____

Medicaid Client: _____ **Medicaid number:** _____

ACS phone number: _____

I authorize the hospital, and attending physician/dentist to submit claims to this company and to Medicaid, and hereby assign benefits directly to them.

Name: _____ **Date:** _____

Witness: _____ **Date:** _____