



BEST PRACTICE RESOURCE SAMPLE

Emergency Medical Treatment Authorization

I give _____, and his/her employees permission to obtain
(Care provider's name)

emergency medical/dental treatment for my child, _____
(Child's name)

Child's Physician: _____ Phone: _____

Physician's address: _____

Child's Care Care Number: _____

Parent's Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone # _____

Parent Signature

Date

Care Provider signature