



# Meeting Street Bright Futures

## Emergency Contact and Medical Treatment Authorization

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

Last

First

Middle

Address: \_\_\_\_\_

Street

City

State/ ZIP Code

<b>Father/Guardian</b>	<b>Mother/Guardian</b>
Name	Name
Employer	Employer
Business Tel.	Business Tel.
Home Tel.	Home Tel.
Cell Tel.	Cell Tel.
E-Mail address	E-Mail address

***In case of an emergency the following persons may be contact and pick up my child:***

Name		
Home Tel.	Business Tel.	Cell Tel.
Relationship		
<b>Physician's Name &amp; Tel.</b>		
Hospital Preference		

I hereby authorize the Meeting Street staff to give consent for any and all necessary emergency medical care required for my child \_\_\_\_\_, while in Meeting Street's custody. I understand that Meeting Street is not liable for any emergency care administered. If necessary, the following insurance information may be given: I carry primary medical insurance of this child? YES \_\_\_ NO \_\_\_. If YES, name of insurance company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

In case of emergency, I hereby authorize the doctor or the hospital to which my child may be taken to perform any emergency procedure or operation, to give treatment and the administration of any anesthetic necessary for the health of my child.

**The following persons are authorized to pick up my child:**

1. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
4. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
5. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
6. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
7. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
8. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
9. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_
10. Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Home Tel. \_\_\_\_\_ Business Tel. \_\_\_\_\_ Cell Tel. \_\_\_\_\_  
Driver's license number or street address: \_\_\_\_\_

The authorization granted by this form will be used only where absolutely necessary and only after every attempt has been made to contact the parent/guardian. Doctors and hospitals refuse to give treatment regardless of how minor, unless they have authorization from parents/guardians. As time can be essential in a medical emergency, this form would assure your child of receiving prompt, professional medical attention.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness/Interpreted by: \_\_\_\_\_ Date: \_\_\_\_\_