Milford Christian School

EMERGENCY TREATMENT CONSENT FORM

Should Milford Christian School need to seek emergency medical treatment for your child, please provide the following information and authorization for us in advance. Please also know that persons under eighteen years of age cannot authorize treatment for themselves.
Please print clearly.

DATE: _____

To Family Doctor or Emergency Physician on Duty: This completed consent form is provided as authorization for you to provide any emergency treatment necessary if parental/guardian consent cannot be obtained in a timely manner.

Name of Child _____ Date of Birth _____

Allergies: _____ Date of Last Tetanus Shot: _____

Family Doctor: _____ Phone Number: _____

Insurance Company: _____ Policy Number: _____

Father's Name (Print): _____ Signature: _____

Father's Address: _____ Phone Number: _____

Mother's Name (Print): _____ Signature: _____

Mother's Address: _____ Phone Number: _____

Witness Name (Print): _____ Signature: _____

Witness Address: _____ Phone Number: _____

Witness Name (Print): _____ Signature: _____

Witness Address: _____ Phone Number: _____