



**EMERGENCY INFORMATION AND PERMISSION FOR MEDICAL TREATMENT**

**Medical Information and Health Concerns**

Pediatrician Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Name \_\_\_\_\_ Policy No \_\_\_\_\_

**Note: Child will be taken to Wellstar Douglas Hospital, Douglasville in case of an emergency.**

Does your child have any allergies to medication, food, or is your child on any medication? \_\_\_\_\_

If so, please specify \_\_\_\_\_

Does your child have any special physical limitations? \_\_\_\_\_ If so, please specify \_\_\_\_\_

Has your child ever been exposed to tuberculosis, hepatitis, AIDS, or any other contagious diseases? \_\_\_\_\_

If so, please specify \_\_\_\_\_

Anything else you would like us to know? \_\_\_\_\_

**Persons who are to be contacted in case of an emergency.**

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

***In the event that I cannot be reached, I give permission for my child to be treated/transported by professional medical personnel. I will assume full responsibility for all charges related to the above. I approve any necessary treatment to be administered as first aid to my child until my arrival.***

Signature \_\_\_\_\_ Date \_\_\_\_\_