

**Medical Consent Form**

In case of emergency,

has my

consent to authorize medical care for my child(ren) listed below:

Our family physician is:

His/her address is:

His/her telephone # is:

Our hospital preference is:

Allergies:

Contact me immediately at:

If unable to contact me, please call:

**Name**

Telephone

**Name**

Telephone

***Signed by***

Name:

Address:

Telephone:

Date: