Voluntary Registration
Child's Emergency Medical Authorization
(Model Form)

Name of Child: _____ DOB: _____

Name of Parent(s) or Guardian: _____

The parent/guardian authorizes _____ to obtain immediate care and
Name of Voluntarily Registered Provider
consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to his/her child if an emergency occurs when he/she cannot be located immediately.

It is understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses. _____ Yes ____ No

2. Medical treatment costs are covered by:

   a. Medical Insurance
      Name of Insurance Company: _____
      Identification Number: _____
      Group Number: _____

   b. Medical Assistance Plan: _____
      Identification Number: _____

   c. No Insurance: _____

Child's Physician: _____
Address: _____
Telephone: _____

Parent Emergency Contact:
Mother: _____
Contact #: _____
Father: _____
Contact #: _____

_____ _____
Signature of Parent of Guardian Date

This form is to be kept by the voluntarily registered family day provider and is to be taken to the doctor or treatment facility in case of emergency.