Proxy Medical Consent Form

ONE CHILD PER PAGE

EFFECTIVE DATE: _____ TO_____

Child's Name_____

Date of Birth; _____ Home Phone: _____

Parent's Name: _____

Father's Employer: _____ Phone #:_____

Mother's Employer: _____ Phone#:_____

Insurance Company: _____ ID #:_____

Child's Last Tetanus Shot: _____ Child's Physician: _____

List of Allergies: _____

List of Medications: _____

Past Medical History: _____

Name of person to call in **Emergenc**y other than parents: _____

Home Phone: _____ Work Phone: _____

List of People with Permission to Sign for Medical Treatment;

1._____ 2._____

3._____ 4._____

5._____ 6._____

Additional Comments: _____

Parent's Signatures: I/WE authorize the above named individual(s) to consent to treatment, and authorize the billing of the insurance and/or parent/guardian on this form.

Mother's Signature: _____ Date: _____

Father's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

01/16/13