EMERGENCY ROOM TREATMENT / LIMITED POWER OF ATTORNEY

Name(s) of Child
or Children:_____
last first middle birthdate

_____

_____

_____

Name of Parent(s) or Legal Guardian_____
last first middle

The undersigned does hereby grant to the individuals listed below, (name one or two adult individuals who will be responsible for the care of your child or children in your absence).

_____ _____
Name of Responsible Adult phone no. Name of Responsible Adult phone no.

The limited Power of Attorney to act for me and to give the required consents and authorizations for the delivery of medical care, diagnoses and treatment, if necessary, for a period of time during my absence from ____ _____ to _____, and to do all other necessary things as I might or could do if personally present.

_____
(NOTARY SEAL) Signature of Parent (or Legal Guardian) /Relationship Date

_____ _____
Witness or Notary Public Date Signature of Parent (or Legal Guardian) /Relationship Date

_____
Address

Information:
Private Physician:_____

Insurance:_____
Company Number

Known Allergies/Significant Medical History:_____

_____

_____

Last tetanus immunization (list for each child):_____

_____

Phone number and address where parents can be reached:_____

_____