



203 Dick Buchanan Street
 La Vergne, TN 37086
 (615) 213-0499

4050 Mercy Ct
 Murfreesboro, TN 37128
 (615) 895-4741

Emergency Medical Authorization

Name of Child:			
Last Name	First and Middle Name (s)	Date of Birth (mm/dd/yy)	
Name of Parent(s) or Guardian:			
Last Name	First Name	Relationship	
Home Address			
Place of Mother's Employment:			
Address			Telephone
Place of Father's Employment:			
Address			Telephone
The parent(s)/guardian authorizes _____ to obtain immediate care and 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, with the following exceptions: <small style="margin-left: 100px;">(Name of licensed Provider)</small> _____ _____			
It is also 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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Medical treatment costs are covered by:			
a. Medical Insurance <input type="checkbox"/>			
Name of Insurance Company		Identification Number	Group Number
b. No Insurance <input type="checkbox"/>			
Child's Physician:	Last Name	First Name	Telephone:
Address			
Hospital you prefer:			
Are there any known allergies, health or medical conditions that the Provider should be made aware of? Circle YES or NO. If yes, please describe: _____ _____ _____			
Emergency contact if parent(s) or guardians is not available: Name and addresses of persons to be contacted and to whom the child may be released (must give two contacts):			
Name	Relationship	Address	Telephone
Name	Relationship	Address	Telephone

Signature of Parent or Guardian

Date (mm/dd/yy)