

CITY OF TREASURE ISLAND
MEDICAL EMERGENCY RELEASE FORM

TO WHOM IT MAY CONCERN:

I hereby give my consent to any EMERGENCY MEDICAL SERVICE/HOSPITAL FACILITY AND/OR PHYSICIAN to administer necessary treatment to my child in the event of an emergency at which time I cannot be reached.

(Name of child)

I give consent to transport by AMBULANCE/MEDICAL SERVICE to such hospital facility EMERGENCY MEDICAL SERVICE deems appropriate.

Physician: _____ Address: _____ Phone#: _____

Allergies: _____

Date of last DPT or Tetanus: _____

Insurance company covering child: _____

Policy number: _____ Date of Issue: _____

(Signature of parent or legal guardian)

(Date): _____

State of _____

County of _____

On the _____ day of _____, 20____, before me came _____, to me known and who executed the foregoing instrument and acknowledge that he executed the same.

NOTARY PUBLIC: _____