EMERGENCY INFORMATION

I,____________________________ , give permission to the doctors at Hendricks Regional Health, I U Health West Hospital, or my family doctor, ____________________ at _______________, to give treatment to my child, _________________________, in the event I cannot be reached during an emergency.

Current Address:____ Phone:_________________

Child's Religious Background:_________________________ Child's DOB:___________________

Known Allergies or Medical Conditions:____

Responsible Party:______________________ Relationship to Child:___________________

Insured Party's SSN:____

Hospital Insurance Information:____

Nearest Relative (not living with child):________________________ Phone:_________________

Address:____

Family Physician:___________________________________ Phone:_________________

Address:____

Family Dentist:______________________________ Phone:_________________________

Address____

Signature of Responsible Party:

____

COUNTY OF: ________________________

The foregoing document was subscribed and sworn to before me on ____________(Date)

My commission expires:_________________

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NOTE: THIS FORM IS INVALID WITHOUT NOTARIZATION