

Emergency Treatment Consent Form

Child/Dependent's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Date of Birth _____

Parent/Guardian _____ Cell Phone (_____) _____

Work Location: _____ Work Phone: (_____) _____

Relationship to Child _____ Email of Parent/Guardian: _____

Physician's Name _____ Physician's Phone number _____

Emergency Contact (if listed parent/guardian is unavailable)

Name _____ Home Phone (_____) _____ Cell Phone(_____) _____

Address _____ City _____ State _____ Zip _____

Relationship to child _____ Work Phone (_____) _____

Health History

Special Medical Problems _____

Last Tetanus Shot (Td) (MM/DD/YY) ____/____/____

Medications to be taken with directions: _____

Medication Allergies: _____

Allergies: (hay, bees, etc): _____

History of Asthma? Y N History of seizures or other loss of consciousness? Y N

History of heart problems? Y N If yes, nature of problem: _____

May be given as necessary: Ibuprofen? Y N Tylenol? Y N

Any specific activities: Encouraged: _____

Discouraged: _____

Health Insurance Company: _____

Group Number: _____ ID Number _____

“I hereby give my consent in advance to the designated leaders _____
(name of leaders) of the Marquette County Junior Fairest of the Fair and to the physicians or
hospital selected by them to render emergency treatment as in their judgment is reasonably
necessary, including, but not limited to, hospitalization, diagnosis including taking specimens
and x-rays, giving blood transfusions and medications, anesthesia and surgery for my dependent
listed above. I understand that the leaders of this program will attempt to contact me before
securing medical treatment, but that this consent is given in case I am not available in an
emergency.

Signature of Parent/Guardian

Date

Signature of Non-Related Adult Witness

Date