JUNIOR BCHW

# MEDICAL INFORMATION
# AND
# TREATMENT AUTHORIZATION

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**CHILD** **DOB**

**ADDRESS**

**CITY** **STATE** **ZIP CODE**

**PARENT** **TELEPHONE**

**ADDRESS**

**CITY** **STATE** **ZIPCODE**

**EMERGENCY CONTACT (IN THE EVENT YOU CANNOT BE REACHED):**

**NAME** **PHONE** **RELATION**

**NAME** **PHONE** **RELATION**

**FAMILY DOCTOR** **HOSPITAL**

**ADDRESS** **CITY** **STATE**

**ALLERGIES**

**ILLNESSES**

**MEDICATIONS**

**I** _____ **PARENT/LEGAL GUARDIAN OF**

_____**AUTHORIZE REASONABLE AND NECESSARY MEDICAL CARE FOR MY CHILD IN THE EVENT I CAN'T BE REACHED. THIS MAY INCLUDE, BUT IS NOT LIMITED TO, TRANSPORTATION, EMS CARE, ER TREAMENT AND SURGERY GIVEN BY A COMPETENT, LICENSED MEDICAL PROFESSIONAL. PARENT/GUARDIAN IS RESPONSIBLE FOR MEDICAL BILLS INCURRED.**

**SIGNATURE:** _____