PARENT EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment at the listed medical facility. This consent will be in effect beginning _____ and will continue while the child is enrolled in the A.S.B. program.

In the event that my child may require medical and/or surgical care while I am unable to be reached, I hereby grant authorization for my child to receive such care at _____ (hospital name) and Doctor _____- or his/her staff or designee to provide this care. I agree to pay/be billed for all the cost and fees contingent on any emergency medical care/or treatment for my child as secured or authorized under this consent.

INSURANCE INFORMATION

Insurance Company/Type: _____ Policy # _____

Insurance Company/Type: _____ Policy # _____

PRIMARY EMERGENCY CONTACTS

Please indicate the individual(s) to be contacted first in the case of an emergency:

Contact 1:	**Relationship:**
Address:	
Home Phone: ( )	**Cell Phone: ( )**
Employer:	**Work Phone: ( )**
Contact 2:	**Relationship:**
Address:	
Home Phone: ( )	**Cell Phone: ( )**
Employer:	**Work Phone: ( )**

*ASB will make every effort to notify the parent/guardian immediately in the event of an emergency

MEDICAL INFORMATION

Child's Name	**Date of Birth**
Allergies	**Medication(s)**
Date of Last Tetanus Vaccination	**Doctor's Name**
Doctor's Hospital/Facility & Address	**Doctor's Phone Number(s)**