



## EMERGENCY MEDICAL AUTHORIZATION FORM

I, \_\_\_\_\_

Parent/ Son/ Daughter/ Guardian of:

\_\_\_\_\_

Born on \_\_\_\_\_, do hereby give my consent to The Newton School to secure and authorize such emergency medical treatment as the above name might require while under the supervision of said care provider. I also agree to pay all the costs and fees contingent on emergency medical care or treatment for this person as secured or authorized under this consent.

NOTE: Every effort will be made to notify the parents/ son/ daughter/ guardian, etc. in case of an emergency. In the even of an emergency, it would be necessary to have the following information:

Physician's Name and phone number: : \_\_\_\_\_

Preferred  
Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Insurance company: \_\_\_\_\_

ID \_\_\_\_\_ Group: \_\_\_\_\_

If the parents are not available, other relatives or persons to contact in emergency:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature of parents: \_\_\_\_\_

Date: \_\_\_\_\_