NSU NOVA SOUTHEASTERN UNIVERSITY
Mailman Segal Center for Human Development

AUTHORIZATION FOR EMERGENCY TREATMENT

Child's Name: _____

To Whom It May Concern:

I hereby give my permission to the nearest hospital, to administer necessary treatment to my child, _____ in the event of an emergency at which times
(Name of Child)

I cannot be reached. Additionally, I give consent for my child to be transported by ambulance if the situation warrants it.

Name of Child's Physician: _____ Phone: _____

My Child is Allergic To: _____

Date of last DPT or Tetanus: _____

Insurance Company Covering My Child: _____

Name of Policy Holder: _____

Policy Number: _____ Expiration Date: _____

_____ _____

(Signature of Parent or Legal Guardian) **(Date)**