EMERGENCY INFORMATION

I, ________________________________ give permission to the doctors at Community Hospital North or my family doctor, ________________________________, to give treatment to my child, ________________________________, in the event I cannot be reached in case of an emergency.

My address is ________________________________ Phone ________________________

Child's Religion ________________Child's Age ______Date of Birth ________________

Known allergies are ____

Responsible Party________________________Relationship ________________________

Employer's address ____

Insured party's S.S. # ____

Hospital Insurance Information ____

Nearest relative at different address ____

Address______________________________________Phone_________________________

Family Physician's Name ____

Address ____________________________________ Phone ________________________

Dentist Name ____

Address______________________________________Phone ________________________

Signature of Responsible Party

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