RCHA MEDICAL CONSENT FORM

In case of emergency, _____ has my consent to authorize medical care for my child(ren) listed below:

_____ _____

_____ _____

_____ _____

Our family physician is: _____

His / Her address is: _____

His / Her telephone number is: _____

Our hospital preference is: _____

Allergies: _____

Contact me IMMEDIATELY at: _____

If unable to contact me, please call:

_____ @ _____
Name Telephone

_____ @ _____
Name Telephone

Signed: _____ Date: _____

Print Name: _____

Address: _____

Telephone: _____