EMERGENCY CARE/CONSENT FOR TREATMENT

Patients Name___________________________________Date of Birth_____________

I hereby give permission to the physicians of Jacksonville Pediatrics to direct any emergency medical treatment to my children during my absence.

It is understood that they will make every effort to contact me in case of medical emergency. It is further understood that if they are unable to contact me, that I give them this permission with my full consent.

If hospitalization is necessary, I direct the physicians of Jacksonville Pediatrics to arrange admission. I will be financially responsible for all hospital expenses.

For non-urgent care (well care, immunizations, minor illnesses, etc) it is necessary for you to list the individuals to whom you have given permission to bring the child in for care. Please list them below:

Name	Relationship to Child (aunt, neighbor, etc)
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

Date:_____________ Signed:____

Witness:______________________________________