Family Support Center
435 Columbian Street
Weymouth, MA 02190

Medical Consent Form

Name: ____________________ Date of Birth: ____________________

Address: ____________________ Phone: ____________________

Medical Provider Information:

Insurance Provider: ____________________ Policy Number: ____________________

Physician: ____________________ Physician's Phone: ____________________

Physician's Address: ____

In Case of an Emergency Contact:

Name	Phone	Relationship
Name	Phone	Relationship

Known Medical Problems and Medications:

This information is included to provide information to emergency personnel of medical problems and medications in an emergency situation.

Existing Medical Problem *(Example: Asthma)*	Medication Taken *(Example: Combivent)*	Dosage Taken *(Example: 2 puffs)*	Dosage Frequency *(Example: "Twice Daily")*

Medical Consent Authorization:

In the event of an injury, accident, illness or other emergency, and if the above stated physician cannot be reached, I authorize_myself _____________my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians and other emergency room personnel such as nurses and laboratory technicians. I agree to accept financial responsibility for the costs related to this medical treatment.

Name ____________________ Phone ____________________ Date Signed ____________________

Name of Authorized Parent or Guardian ____________________ Phone ____________________ Date Signed ____________________

Note: This form is designed to present general consent for emergency medical treatment and may not include all the requirements of your state. You should consult with a legal professional to ensure that all of your medical, legal and financial rights are protected.