The Dick Howser Center
For Childhood Services, Inc.
3519 Easter Stanley Court ~ Tallahassee, Florida 32308
P: (850) 921-KIDS(5437) ~ F: (850) 921-4734

EMERGENCY MEDICAL AUTHORIZATION

I (We) _____ and _____
Parent/Guardian Parent/Guardian

of _____
Street City State Zip Code Country

do herby state that I am (we are) the parent(s) or legal guardian(s) having legal custody of

_____, born _____
Child's Name Birth Date

who resides with me (us) at the address listed above, do authorize the Director or any employee of the Dick Howser Center to consent to any x-ray examination, anesthetic, medical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the State of Florida when such treatment is immediate, and when efforts to contact me (us) are unsuccessful.

Hospital Preference: ❍ Tallahassee Memorial Hospital ❍ Capital Regional Medical Center

❍ Other: _____

Child's Doctor: _____ Phone Number: _____

Parent's Doctor: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The forgoing instrument was acknowledged before me this _____ day of _____, 20____.

_____
Print, Type of Stamp Name of Notary

_____ Personally Known

_____ Or Produced Identification

_____ Type of ID and ID# _____