

**TAVON CENTER**  
**Consent for Emergency Medical Treatment**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Home Address Home

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Contact Phone Number

In the case that I cannot be contacted during a medical emergency I give consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, etc.), for the above named person, which may be required during my absence. If circumstances permit, I would like to have our doctor consult in connection with such treatment.

Please attempt to contact me at the following telephone number: \_\_\_\_\_

This consent serves as permission for treatment by \_\_\_\_\_ (Hospital Name).

**Signatures**

\_\_\_\_\_  
Parent/Guardian (circle one) Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**TAVON CENTER**  
**Emergency Medical Information**

Participant name: \_\_\_\_\_

Date: \_\_\_\_\_

**Family Physician Information**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

**Insurance Information**

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Policy Number

**Chronic or existing medical conditions**

(E.G., Asthma, Seizures, Diabetes)

**Known Allergies**

Anesthetics    Insect Stings    Penicillin  
Aspirin        I.V.P. Dyes        Shellfish  
Codeine        Morphine        Tetanus Toxoid  
Demerol                    Novocaine  
Antibiotics (Please List)  
Other (Please List)

**Current Daily Medications**

- 1.
- 2.
- 3.

**Recent Shots and Vaccines**

Tetanus/Date

Other/Date

10/08