Emergency Treatment Information and Authorization

I, (name of parent) _____, agree to the administration of emergency medical treatment to my child, (name of child) _____ , by duly qualified health practitioner in my absence. I authorize (name of provider) Project Self-Sufficiency Project Launch to arrange for such emergency medical treatment until such a time I can be present.

(Sign in presence of notary or witness)

Signature_____ Date_____

(OPTIONAL: to be filled out by notary public)
Sworn and subscribed before me at this _____day of_____20_____

(REQUIRED)

Signature of notary or witness:_____

Date:_____

Health Care Provider Information:

Provider Name: _____

Phone Number: _____