Consent to Emergency Treatment

Patient Information

_____ _____ _____
Child's Name (Last, First, MI) *Date of Birth* *Age*

_____
Street Address

_____ _____ _____
City *State* *Zip*

I, (parent/legal guardian – circle one) _____, agree to TriHealth providing emergency treatment to (child's name) _____ should my child need emergency treatment after receipt of either dose of the COVID-19 vaccine. All efforts will be made to contact the emergency contacts in the order listed below as soon as possible related to any unforeseen emergency involving my child, but I understand that emergency treatment will be provided, as needed, before contacting me.

_____ _____ _____
Parent/Legal Guardian's Signature *Date* *Time*

_____ _____
Parent/Legal Guardian's printed name Parent/Legal Guardian's phone number

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_____ _____
First emergency contact name (can be parent listed above) First emergency contact - relationship to minor

_____
First emergency contact phone number

_____ _____
Second emergency contact name (can be parent listed above, but only if not listed as first contact) Second emergency contact - relationship to minor

_____
Second emergency contact phone number