EMERGENCY TREATMENT PEDIATRIC WEIGHT-BASED DOSAGE AUTHORIZATION

Date: [Date]

Patient Information:
Child's Full Name: [Child's Name]
Date of Birth: [Date of Birth]
Current Weight: [Weight in kg/lbs] as of [Date Weight Taken]

Parent/Guardian Information:
Name: [Parent/Guardian Name]
Phone Number: [Phone Number]
Emergency Contact: [Alternative Contact Name and Phone]

Medical Provider Information:
Physician Name: [Doctor's Name]
Clinic/Hospital: [Clinic Name]
Phone Number: [Doctor's Phone Number]

Authorization:

I, [Parent/Guardian Name], hereby authorize qualified medical personnel, emergency medical technicians (EMTs), or school/childcare nursing staff to administer medications to my child, [Child's Name], in the event of an emergency.

Dosages should be calculated based on the child's most recent weight of [Weight] as recorded above, following standard pediatric medical protocols or the specific instructions listed below:

- **Allergy/Anaphylaxis:** [Insert medication/dosage if specific]
- **Seizure:** [Insert medication/dosage if specific]
- **Asthma:** [Insert medication/dosage if specific]
- **Other:** [Insert instructions]

Known Allergies: [List all allergies or write NONE]

Current Medications: [List current medications]

This authorization is valid from [Start Date] to [End Date].

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Signature of Parent/Guardian

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Signature of Physician (Optional but Recommended)