

**Indiana University Southeast Children's Center
Emergency Medical Transportation Release**

Date _____

I, the undersigned, give my permission for the IUS Children's Center to have my child
_____ transported and treated at Floyd Memorial Hospital in the
event of a medical emergency.

Parent Name _____

Parent Signature _____

Address _____

City/state/zip _____

Home phone # _____ Work Phone # _____

Witness Name _____

Witness Signature _____

Date _____