EMERGENCY MEDICAL AUTHORIZATION FORM

Today's Date _____

Child's Name _____ Birthdate _____

Home Address _____ Zip _____

Home Telephone _____

Mother's Employer (if applicable) _____

Work Phone_____ Cell Phone _____

Father's Employer (if applicable) _____

Work Phone_____ Cell Phone _____

Best Email Address_____

ALTERNATE EMERGENCY NUMBERS (in the event that the mother/father cannot be reached)

1. _____ Phone _____ Relationship _____

2. _____ Phone _____ Relationship _____

3. _____ Phone _____ Relationship _____

AUTHORIZATION FOR TREATMENT

As parent or legal guardian of _____, I give permission for my child to attend and participate in activities sponsored by the Early Childhood Center. Should it become necessary for my child to receive emergency care, I give permission for my child to be transported to the nearest hospital, emergency care facility, or doctor's office by car or emergency vehicle and I will be responsible for any expenses incurred.

I further give my permission for any reasonable medical or dental treatment deemed necessary by a licensed physician or dentist and agree to pay all expenses incurred with the treatment of my child.

Insurance Provider _____

Physician's Name_____Physician's Phone _____

Parent/Guardian Signature _____ Date _____

early childhood center
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