Authorization for Emergency Medical Care/Treatment

Community of Faith Preschool

Child's Name: _____

Child's Birth Date: _____

If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give authorization to obtain emergency medical care and to transport the child for emergency medical treatment to:

Name of Physician _____

Address of Physician _____

Phone # of Physician _____

AND:

Name of Hospital or Clinic _____

Address of Hospital _____

Phone # of Hospital _____

List of any special problems that your child may have such as allergies, existing illnesses, previous serious illnesses, injuries and/or hospitalization during the past 12 months, medication prescribed for long-term use, any possible reactions to medication they may be taking or need in an emergency; any other information which emergency medical personnel should be made aware of: **(Please write none if there are not any known.)**

_____

_____

_____

_____

_____

I give consent for necessary emergency treatment when my child is in the care of this physician, hospital or clinic.

_____ _____

Signature of Parent or Legal Guardian **Date**

_____

Cell Phone Number