Child's Emergency Medical Authorization

Name of Child: _____ DOB: _____

Name of Parent(s) or Guardian: _____

The parent/guardian authorizes _____ to obtain immediate care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to his/her child if an emergency occurs when he/she cannot be located immediately.

It is understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise, he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses. _____ Yes ____ No
2. Medical treatment costs are covered by:

a. Medical Insurance
   Name of Insurance Company: _____

   Identification Number: _____

   Group Number: _____

b. Medical Assistance Plan: _____
   Identification Number: _____
c. No Insurance: _____

Child's Physician: _____ Physician Phone: _____

Physician Address: _____

Parent/Guardian Emergency Contact:

Parent/Guardian: _____ Contact #: _____

Parent/Guardian: _____ Contact #: _____

Signature of Parent or Guardian **Date**

*This form is to be kept by school and is to be taken to the doctor or treatment facility in case of emergency.