

# Authorization for Emergency Treatment

The **Children's Garden Preschool** has my permission, in an emergency when I, or the legal guardian or designated emergency contact cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well being of my child. I agree to accept the financial responsibility for all medical expenses incurred.

Child's Name \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Child's Allergies (if any) \_\_\_\_\_

Child's Pediatrician; Dr. \_\_\_\_\_ Telephone Number \_\_\_\_\_

Family Dr. \_\_\_\_\_ Telephone Number \_\_\_\_\_

Medicines Child is Taking: \_\_\_\_\_

Last Tetanus Shot: \_\_\_\_\_

Outstanding Medical History (example: Diabetes, Heart Disease, etc.):  
\_\_\_\_\_

Preferred hospital when and if available: \_\_\_\_\_

## **Insurance Information:**

Insurance Company: \_\_\_\_\_

Identification/Policy Number/Group Number: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Place of Employment and Phone Number: \_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_