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**Child’s Emergency Medical Authorization**

Name of Child Birth date

Name of Parent(s) or Guardian

Home Address Telephone #

Place of Mother’s Employment Telephone #

Address Cell #

Place of Father’s Employment Telephone #

Address Cell #

The Parent(s)/guardian authorizes

(Name of Day Care Center Operator)

to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to, his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also 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.

2. Medical treatment costs are covered by:

a. Private Insurance (name & policy no.)

b. Medicaid Coverage No.

c. Other medical insurance:

Name of Insurance Company

Policy No.

d. No insurance

Child’s physician or clinic attended

Attached is a copy of the agreement with:

Child’s parent(s) or guardian and the day care center operator. Yes No

Signature (Parent(s)/Guardian) Date

This form is to be kept by the day care operator and is to be taken to the doctor or treatment facility in case of emergency.