

Emergency Medical Authorization Form

I/we, the undersigned, give permission for, _____
Name of Provider

Provider Address

Day Care Provider

Relationship to child

to provide for my/our child

Name of Child

Date of Birth

any and all personal care, including any and all emergency medical attention
authorized by a medical doctor.

Known Allergies: _____

Medical Conditions: _____

In the event of a medical emergency, I /we understand that my/our child will be
transported to the nearest hospital. All expenses including transportation will be
provided by:

Insurance Company

Policy Number

Parent Signature

Date

Parent Signature

Date

Other Responsible Party Signature

Date