Trinity Presbyterian Preschool

Emergency Medical Treatment Authorization

(All information MUST be completed to accept form.)

Child's Name_____Birthdate_____

Medications child is taking_____

Allergies (food and drugs) _____

Name of Parent/Guardian _____

Address _____

Phone Numbers: Home_____ Cell _____ Office_____

Other numbers where I may be found_____

Someone who will know where to find me _____ Phone _____

Family Physician or Immediate Care Center _____ Phone _____

Preferred Hospital for Emergency Treatment (EMS) _____

Insurance Company_____

Policy Number _____ Policy Holder _____

If I cannot be located by the above means, please contact the following persons in the event of an emergency:

Name_____Phone_____

Relationship to child _____Cell _____

Name_____Phone_____

Relationship to child _____Cell _____

Name_____Phone_____

Relationship to child _____Cell_____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION: In case of a medical emergency involving the minor listed above, I request the doctor/dentist/hospital staff to contact me or my spouse at the numbers provided. In the event that my spouse or I **cannot be reached,** I grant written permission to the Director at Trinity Presbyterian Preschool or her designee, to authorize the appropriate medical/dental/hospital personnel to render emergency medical care which is deemed appropriate. I (we) agree to pay for the treatment or medication received by said child, and release Trinity Presbyterian Preschool from all claims or liability arising from said emergency medical treatment.

_____ _____

Parent/Guardian Signature Date