

Child's Emergency Medical Authorization Form

| | | |
|----------------------------------------|-------------------------|-------------------|
| Name of Child | Date of Birth | |
| Name of Parent(s) or Guardian | Home Phone | Cell Phone |
| Home Address | | |
| Mother or Guardian's Employment | Employment Phone | |
| Employment Address | | |
| Father or Guardian's Employment | Employment Phone | |
| Employment Address | | |

The Parent(s) or Guardian authorizes the Classroom of Discovery to obtain immediate medical care and consents to the hospitalization of and/or the performance of necessary diagnostic tests 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.

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. No Insurance _____

Child's Physician _____ Phone _____

Address _____

Signature of Parent or Guardian

Date

This form is to be kept by The Classroom of Discovery and is to be taken to the physician or treatment facility in case of emergency.