Permission for Health Care

Child's name _____Date_____

Child's physician_____Phone_____

Address_____

Child's dentist _____Phone _____

Address _____

AUTHORIZED ADULTS

In the event of an emergency, please indicate your name and phone number where you and another authorized person can be reached

Father's name _____Phone_____

Mother's name _____ Phone _____

Emergency contact _____ Phone _____

Address _____

FIRST AID

In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary for my child.

_____

signature/date

EMERGENCY CARE

In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

_____

signature/date

HEALTH RECORD TRANSFER

In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital.

_____

signature/date