CHILD'S EMERGENCY MEDICAL AUTHORIZATION

THIS FORM IS TO BE KEPT BY THE CHILDCARE CENTER OPERATOR AND IS TO BE TAKEN TO THE DOCTOR OR TREATMENT FACILITY IN CASE OF EMERGENCY.

If my child ___________________________________, date of birth _____________________________________, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or Health Provider to give the emergency medical treatment required:

Hospital Name
Address

OR

Health Provider (Name)	Telephone number
Address	

I give permission to ____ (name of child care center), located at 6481 Little River Turnpike Alexandria, VA 22312, to obtain immediate care and consents to the hospitalization of the performance of diagnostic test upon, the use of surgery on and/or the administration of drugs to my child. It is also understood that this agreement covers only those situations, which are true emergencies and only when I cannot be reached. I accept responsibilities for any necessary expense incurred in the medical treatment of my child.
Do you have a medical insurance for your child? YES___________ NO ___________

If Yes, please fill out the information below.
Medical treatment costs are covered by:

Health insurance company	
Name of policy holder	Relationship to child
Policy number	Coverage
Medical number	State

Child's known allergies or health condition: (If yes, please explain):

____
____
____
____
____

Home address: ____

Telephone No: ____

Parent(s)' s signature	Relationship to child	Date