## Emergency Medical Treatment Authorization

Name of Child: _____

Nicknames: _____ DOB: _____ Class: _____

Mother's First & Last Name: _____

Father's First & Last Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home #: _____

During preschool hours Mother's phone #: _____

During preschool hours Father's phone #: _____

Child may be released to: O mother O father O other (listed below)

If parents cannot be reached, please list authorized contacts and pick up:

Contact 1: _____ Relationship to Child: _____

Phone #: _____

Contact 2: _____ Relationship to Child: _____

Phone #: _____

Contact 3: _____ Relationship to Child: _____

Phone #: _____

Contact 4: _____ Relationship to Child: _____

Phone #: _____

Health Information

Allergies _____

Physical or Emotional Issues _____

Overall State of Health _____

Doctor's Name: _____ Phone #: _____

Doctor's Address: _____

- I authorize the center staff to administer first aid treatment to my child.
- I authorize the person in charge to arrange emergency transportation to:

Hospital: _____ Phone #: _____

Hospital Address: _____

- I give consent for any and all necessary treatment when my child is in the care of this physician and/or hospital/clinic.
- I accept the policies and regulations of the Edge Park United Methodist Preschool and release it from any and all liability for injuries or illness resulting from conditions or circumstances beyond its control. I will accept the emergency medical physician if my physician is not available at the time of an accident or illness.

Parent Signature: _____ Date: _____


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Father's First & Last Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home #: _____

During preschool hours Mother's phone #: _____

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Parent Signature: _____ Date: _____