

**EMERGENCY MEDICAL AUTHORIZATION
CREATIVE CHILDCARE CENTER & ACADEMY**

Name of child _____ Birthday _____

Name of parent (s) or guardian _____

Home address _____ Telephone _____

Place of mother's employment _____ Telephone _____

Address _____

Place of father's employment _____ Telephone _____

Address _____

The parent (s) guardian authorizes **CREATIVE CHILDCARE CENTER AND IT'S STAFF**

to obtain immediate medical care and consent to the hospitalization and 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. It is also understood that this agreement covers only those situations which are true emergencies and only when he / she cannot be reached. Otherwise he / she expects to be notified immediately.

1. I / We will be responsible for payments of medical care expenses _____

2. Medical treatment costs are covered by

Name of Insurance Company _____

Policy No. _____

Child's physician or clinic name _____ Telephone _____

Hospital's name _____ Telephone _____

Address _____

Allergies / Medical problems

Medicines to administer _____ to avoid _____

Date _____ _____

(signature of parent (s) / Guardian

This form is to be kept by the licensed care provider and is to be taken to the doctor or treatment facility in case of emergency.