

Authorization for Emergency Medical Attention

Child Care Center			Today's Date (mm/dd/yyyy)			
CHILD Information						
Legal Name: Last Name	First Name	Middle Name Birthd		Birthdate (mm/	date (mm/dd/yyyy) Gender	
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ALITHODIZATION FOR EMERCENCY MEDIC	CAL ATTENTION					
AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION						
In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:						
PHYSICIAN Information						
Name:						
Address (Chrost name building and/or ant # City Chate 7/D)						
Address: (Street name, building and/or apt. #, City, State ZIP)						
Phone:						
EMERGENCY MEDICAL CARE FACILITY Information						
Name:						
Address: (Street name, building and/or apt. #, City, State ZIP)						
Tida. 225. (Screet name, Sanama and of apt.	, c.t.j, state 211 j					
Phone :						
I give consent for the facility to secure any and all necessary emergency medical care for my child.						
Signature of Parent Guardian			Date			

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