

**EMERGENCY MEDICAL AUTHORIZATION**

Should \_\_\_\_\_, \_\_\_\_\_ suffer any injury  
(Child's name) (Date of Birth)  
Or illness while in the care of \_\_\_\_\_ and the facility is  
(Name of facility)

Unable to contact me/us immediately, it shall be authorized to secure such medical attention and care for the child as necessary. I/we agree the facility informed of changes in telephone numbers, etc. where I /we can be reached.

The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

Child's primary source of health care is:

\_\_\_\_\_  
Physician/Clinic Name Telephone Number

Known medical conditions (i.e.) diabetic, asthmatic, drug allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian signature) (Date) (Telephone)