CHILD'S EMERGENCY MEDICAL AUTHORIZATION

Child's Name _____ Birthdate _____

Name of Parent(s) _____ Home Phone _____

Home Address _____ City _____ State _____ Zip _____

Father's Place of Employment _____ Work Phone/Cell Phone _____

Mother's Place of Employment _____ Work Phone/Cell Phone _____

Persons or Agencies Having Legal Custody of the Child:

Special Instructions Regarding Custody: _____

Persons Authorized to Pick-up Child: _____

Persons Not Authorized to Pick-up Child: _____

Note: Appropriate paperwork, such as divorce decree will be attached if a parent is not allowed to pick-up the child.

The parent(s) / guardian authorized **COUNTRY WOODLAND SCHOOL** to obtain immediate medical care and consent to the hospitalization of, the performance of necessary diagnostic test 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 that 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 payment of medical expenses. _____
   Signature of Parent / Guardian
2. Medical treatment costs are covered by:
   A. Medicaid Coverage number: _____
   B. Other Medical Insurance:
      Name of Insurance Company: _____
      Policy Number: _____
   C. No Insurance: _____
      Signature of Parent / Guardian

Child's Physician: _____ Phone: _____

Child's Allergies: _____

Outstanding Medical History (Diabetes, Heart Disease, Asthma, etc.): _____

Medication Child is Taking _____

_____ _____

Parent / Guardian Signature Date

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