Authorization for Emergency Treatment

Child's Name: First ______________________ Last _______________________ Date of Birth __________

Date of Last Tetanus shot (Dtap/Tdap): _______________________________ Boy Girl

Child's Dr.: ____ Phone No.:____________________________

Outstanding medical history (please include all **allergies** as well as any ongoing **medications**):

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Mother's Name: First: _________________________________ Last: _________________________________

Address _____________________________________City___________________ State______ Zip: ________

Phone: Home: ____________________ Cell _______________________ Work: ______________________

Father's Name: First: _________________________________ Last: _________________________________

Address _____________________________________City___________________ State______ Zip: ________

Phone: Home: ____________________ Cell _______________________ Work: ______________________

Insurance Company: ____

Identification / Policy No: ____

Policy Holder's Name: ____

Policy Holder's Employer: ____

In case of a medical emergency, Fairfax United Methodist Church Preschool has my permission to transport my child by emergency medical services transport to the emergency room of the nearest hospital and provide this health information. The emergency medical services team, hospital and its medical team have my authorization to provide treatment which is deemed necessary for my child's well-being. I agree to accept responsibility for medical and transportation fees.

___________________________________ ___________________________________ ________________

Signature of Parent or Guardian Printed Name of Parent or Guardian Date

Revised: 4/18