Emergency Care Authorization

Name of Child_____ Date of Birth _____

Name of Parent/Guardian_____ Home Phone _____

Address_____ Zip Code_____

Employer_____ Business phone _____

Name of Parent/Guardian_____ Home Phone _____

Address_____ Zip Code_____

Employer_____ Business phone _____

Name of Child's Physician or Health Clinic: _____

Address: _____ Office Phone: _____

Name of Child's Dentist: _____

Address: _____ Office Phone: _____

Hospital Preference (must provide): _____

Health Insurance: _____ Policy #: _____

Special Health Conditions, if any:

_____

Known Allergies:

_____

Emergency Treatment and Transportation:

I authorize, for emergency purposes only, any designated employee of Montessori Footprints Learning Center to provide my child with emergency transportation and to secure any necessary medical, dental, and/or emergency surgical treatment. I understand that, if possible, my preferred physician, hospital, and or dentist will treat my child.

Signature _____ **Date** _____