

EMERGENCY CARE AUTHORIZATION

Emergency Treatment and transportation:

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

Special Health Conditions, if any:

Known Allergies:

\_\_\_\_\_

Name of child's Physician or Health Clinic:

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital Preferred for emergency treatment:

Health Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_

Name of child's Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_