

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: _____
