EMERGENCY CONTACT AND TREATMENT AUTHORIZATION

Child's Name _____ Home Phone _____
Birth Date _____ Child's SS# _____
Mother's Name _____ Father's Name _____
Bus./Cell Phone _____ Bus./Cell Phone_____

Names of friends or relatives to call, if you cannot be reached:
1. _____ Phone _____ or _____
2. _____ Phone _____ or _____

Physician to be called in an emergency:
_____ Phone _____

Dentist to be called in an emergency:
_____ Phone _____

Allergies: _____
Medicines child is taking: _____
Last Tetanus shot: _____
Outstanding medical history (e.g. diabetes, heart disease) or ongoing medical condition:_____
_____

Health Insurance Information:

Insurance Company: _____
Identification/Policy No.: _____
Subscriber's Name: _____
Subscriber's Place of Employment: _____
Subscriber's Telephone No.: _____

I, _____ (parent or guardian), hereby authorize any physician member of the Department of Emergency Medicine of any area local hospital or any member of the Medical Staffs of the hospital requested by the Department of Emergency Medicine physician, to render medical treatment, which in his/her judgment may be deemed necessary in the care of _____ (name of child). Any expenses will be borne by the child's family.

Date _____ Signature of Parent or Guardian _____

Although special care will be taken, GFUMP workers cannot be held responsible for accidents. The school has my permission, in an emergency, when I (or my physician) cannot be reached, to take my child to the Emergency Room of the nearest hospital. The medical staff there has my authorization to provide treatment, which a physician deems necessary for the well being of my child. Also, Great Falls United Methodist Preschool will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

Date _____ Signature of Parent or Guardian_____