PERMISSION FOR HEALTH CARE

CHILD'S NAME: _____ **DATE**: _____

CHILD'S PHYSICIAN: _____ PHONE #: _____

ADDRESS: _____

CHILD'S DENTIST: _____ PHONE#: _____

ADDRESS: _____

AUTHORIZED ADULTS:
In the event of an emergency, please indicate your name and phone number where you and /or another authorized adult can be reached.

Mother/Guardian Name: _____ Phone#: _____

Father'/ Guardian Name: _____ Phone#: _____

Authorized Adult: _____ Phone#: _____

Address: _____

FIRST AID:
In the event of an emergency, I authorize the staff to provide any first aid care deemed necessary for my child.

_____
Signature / Date

EMERGENCY CARE:
In the event of an emergency in which I can not be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

_____
Signature / Date

HEALTH RECORD TRANSFER:
In the event of an emergency, I hereby authorize the transfer of my child's health records to the local hospital.

_____
Signature / Date