

A CHILD’S WORLD
Emergency Medical Authorization

Should _____, _____ suffer an injury or illness while in the
(Child’s Name) (Date of Birth)

care of _____ and the center is unable to contact me
(Name of Center)

(us) immediately, the center shall be authorized to secure such medical attention and care for the child as may be necessary. I (we) shall assume responsibility for payment of services.

I (we) agree to keep the center informed of changes in telephone numbers, etc. where I (we) can be reached. The center agrees to keep me (us) informed of any incidents requiring professional medical attention involving my child.

Child’s primary source of health care is:

Physician/Clinic Name Telephone No.

Signature of Parent/Legal Guardian Date

Telephone No.