CROSS OF GLORY NURSERY SCHOOL
Cambridge Drive, Aberdeen NJ

PARENTAL AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Child's Name: _____

Age: _____ Date of Birth: _____

Phone: _____ Cell Phone: _____

Parent(s) Name(s): _____

Parent (s) Address: _____

_____

CHILD'S MEDICAL INFORMATION

Medical Problems: _____

Allergies: _____

Medicine(s) Child is Taking: _____

Medicine(s) Child is Allergic To: _____

Name of Child's Doctor: _____ Phone: _____

CHILD'S INSURANCE

Company/HMO: _____

Group Number: _____ Identification Number: _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above child care center's director or director's designee to obtain emergency treatment for my child. I consent to an X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in an emergency:

1. The parent/guardian will be contacted immediately
2. The child's physician will be contacted.
3. We will attempt to contact you through all of the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all of the following:
   a. Call for emergency first aid assistance/transportation. (If an emergency, this call will be made prior to reaching you.)
   b. Call another physician.
   c. Have the child transported to an emergency hospital in the company of a staff member.

Parent Signature: _____ Date of Signature: _____