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: _____
_____