The Episcopal Day School of Evergreen

EMERGENCY HEALTHCARE AUTHORIZATION

Child's Full Name: _____
Birth Date: _____

Mother's Name: _____
Address: _____
City, State and Zip: _____
Home Phone Number: _____ Cell Number: _____
Any Other Numbers: _____

Father's Name: _____
Address: _____
City, State and Zip: _____
Home Phone Number: _____ Cell Number: _____
Any Other Numbers: _____

Child's Physician: _____
Address: _____
City, State and Zip: _____
Phone Number: _____

Hospital of Choice: _____ Phone Number: _____
Insurance Name: _____ Policy Number: _____
Name of Person Financially Responsible: _____

EMERGENCY CARE AUTHORIZATION

In order to protect my child _____ in case of medical emergency, accident, or sudden illness, I, _____ authorize a representative of the Episcopal Day School of Evergreen program to refer my child to his/her own physician _____.

In the event the above mentioned physician cannot be reached, or if time is too critical to attempt to reach me, I request, agree and give approval that my child be transported to the nearest medical facility/hospital of choice. I further authorize the hospital and any attending physicians to perform any and all diagnostic procedures and/or treatments required. In addition, I authorize a representative of the Episcopal Day School of Evergreen to secure any emergency medical transportation necessary. I will assume financial responsibility for the emergency treatment and any medical expenses incurred thereafter.

Parent/Guardian Signature: _____ **Date:** _____