EMERALD CHILD DEVELOPMENT CENTER

1855 Cal Young Rd. 97401 541-485-7464

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

The undersigned parent or guardian of _____

(students full legal name)

hereby authorizes staff of Emerald Child Development Center to seek medical or surgical treatment to this minor student.

Students Date of Birth _____

Parent Name _____ (Cell) Phone _____

Home Address _____

Employer _____ Work Phone _____

Other Emergency Contact _____ Phone _____

Family Physician _____ Phone _____

Health Insurance Co. _____ Group ID _____

Medical conditions, allergies, etc. _____

Current Medications _____

This authorization shall be effective for as long as my student is inrolled at ECDC.

Parent Signature _____ Date _____

AN ATTEMPT WILL BE MADE TO NOTIFY PARENTS IMMEDIATELY IN THE EVENT OF AN EMERGENCEY, BEFORE TREATMENT IS PROVIDED.