EARLY RESULTZ
Daycare & Learning Center

Child's Emergency Medical Authorization

Name of Child: _____ Birth Date: _____

Name of Parent(s) or Guardian: _____

Home Address: _____ Telephone #: (___) ____-_____

Place of Mother's Employment: _____ Telephone #: (___) ____-___

Address: _____ Cell # (____) ____-_____

Place of Father's Employment: _____ Telephone # (____) ___- _____

Address: _____ Cell # (____) ____-_____

The Parent(s)/guardian authorizes **Early Resultz Daycare & Learning Center** to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to, his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise, he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses. _____
2. Medical treatment costs are covered by:
    a. Private Insurance (name & policy number): _____
    b. Medical Coverage Number: _____
    c. Other medical Insurance:
        Name of Insurance Company: _____
        Policy Number: _____
    d. Insurance:_____

Child's Physician or clinic attended: _____

Attached is a copy of this agreement with:

Child's parent(s)/guardian and Early Results Director/Owner: Yes: ____ No: _____

Signature (Parent(s)/Guardian) Date: MM/DD/YYYY

This form is to be kept by Early Resultz Director/Owner and is to be taken to the doctor or treatment facility in case of an emergency.