



## EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) \_\_\_\_\_ Date of birth \_\_\_\_\_ suffer an injury or illness while in the care of (Facility name) \_\_\_\_\_ and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: \_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Facility Administrator/Person-In-Charge: \_\_\_\_\_  
Signature

Date: \_\_\_\_\_