



Children's House of Durango, LLC
Montessori Education

1689 West Third Avenue Durango, CO 81301
970-259-1089

www.childrenshouseofdurango.com

AUTHORIZATION FORM

Authorization for emergency medical care must be obtained from the parent of each student.

Date: _____

I/We _____ hereby give my/our permission to Children's House Staff to call a doctor for medical or surgical care for my/our child, _____ should an emergency arise. It is understood that a conscientious effort will be made to locate me/us before emergency action will be taken, but if this is not possible, the expenses of emergency treatment or care will be accepted by me/us.

Parent/Guardian

Parent/Guardian

Emergency Contact Numbers:

Parent/Guardian Name: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

Parent/Guardian Name: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

Back Up Name: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

Child's Physician Name and Number: _____

Child's Dentist Name and Number: _____