

# Medical Emergency Authorization Card

## Angels of Hope Preschool

Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Home phone \_\_\_\_\_ Social security # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Work phone \_\_\_\_\_ Work phone \_\_\_\_\_

Name of relative/friend \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Out of state contact (in case of natural disaster) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Child's physician \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Child's dentist \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Special instructions if child is injured or ill \_\_\_\_\_

**Medical Release** : I authorize Angels of Hope Preschool to seek emergency medical treatment for my child. I give permission to the emergency physician to secure proper emergency treatment and to order injection, anesthesia, or other emergency treatment if I (we) cannot be contacted. It is understood that a conscientious effort will be made to locate me or my spouse before action is taken. But if it is not possible to locate us, I accept the expense. In the event of life-threatening emergency, I understand that "911" will be called to take my child to my preferred hospital if possible, or to the closest available facility.

\_\_\_\_\_  
Parent/guardian's signature

\_\_\_\_\_  
Date

