MEDICAL AUTHORIZATION FORM

Child's Name: _____ Home Phone: _____

Mother's Name: _____ Mobile Phone: _____

Father's Name: _____ Mobile Phone: _____

Physician Name: _____ Office Phone: _____

Physician Address: _____

Insurance Co. Name: _____ Policy Number: _____

Dentist Name: _____ Office Phone: _____

Dentist Address: _____

Emergency Contacts: The following individuals may be called and are authorized to retrieve your child from Kid's Connection in the event of emergency, if parents cannot be reached.

NAME:	ADDRESS:	PHONE:

List any known allergies: _____

_____

List any known medical conditions: _____

_____

Updates: Written notification must be provided to the Center Director upon any change of the information or contact names / addresses / phone numbers on this form.

AUTHORIZATION: I hereby authorize the Kid's Connection staff to take whatever emergency medical measures deemed necessary to protect my child while under their care. I understand that this may include calling the physician named above, implementing his/her instructions, and transporting my child to the appropriate facility without first obtaining my consent. I understand that I will be responsible for any costs associated with providing medical care to my child.

Parent Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____