



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

*(This form does not need to be notarized, but it is recommended.
If notarized, the form expires when the notary's commission expires.)*

I _____ hereby give my permission to CONNECTIONS Early Learning and Development, LLC to call for medical or surgical care for my child, _____, should an emergency arise. It is understood that a conscientious effort will be made to locate me before emergency action will be taken, but if this is not possible the expenses of emergency medical treatment, transportation, or care will be accepted by me.

Parent/Guardian

Date

Parent/Guardian

Date

Notary

Date

OFFICIAL SEAL

My Commission Expires

YEARLY UPDATE

Parent Signature

Date

Parent Signature

Date

Parent Signature

Date

Parent Signature

Date

ADDITIONAL MEDICAL INFORMATION

Allergies _____

Current Meds _____

Medical Conditions _____

MEDICAL/INSURANCE INFORMATION

This information is voluntary

Company Name _____

Address _____

Telephone _____

Policy Number _____

Policyholder's Name _____

Additional Information _____

DOCTOR/HOSPITAL OF CHOICE

Doctor _____

Address _____

Phone Number _____

Hospital _____

Address _____

Phone Number _____

Dentist _____

Address _____

Phone Number _____

