MEDICAL TREATMENT AUTHORIZATION

Child's Name: _____ Date of Birth: ___/___/___
Parent(s)/
Guardian(s) Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____

I/We hereby authorize _____ Hospital and its staff to perform
(name of preferred hospital)
routine procedures and medical treatment and/or any emergency medical treatment or surgery necessary in the event that he/she should need such treatment and I/we, the parent(s)/legal guardian(s) are not available.

This authorization is effective only in the event of an illness or injury requiring medical treatment while _____ is enrolled in and utilizing the facilities of Kidsabilities Daycare.

I acknowledge that no guarantees have been made to me/us to the result of treatment or examinations in the hospital.

I/We have read and completely understand the contents of this form. The above mentioned child/patient is unable to consent to medical procedures because he/she is a minor of _____ years of age.

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Parent/Guardian Signature) (Date)

Health insurance carrier: _____ Number: _____

Any special instructions for care: (Please detail on flipside of this form)