AUTHORIZATION FOR MEDICAL TREATMENT

If my child, ___________________________________, should become ill or injured at HARVEST TIMECHILD DEVELOPMENT CENTER, I understand that the facility will:

(1) contact me immediately **and/or** ______________________________

(2) contact the person(s) I have designated if I cannot be contacted.

Should the facility be unable to reach me and/or the person(s) I have designated, Harvest Time Child Development Center is authorized to contact my child's physician and/or arrange for immediate emergency treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

Father's Signature _____________________________________Date_________

Mother's Signature ____________________________________Date__________

Person(s) designated if I am unable to be reached:

____

Preferred Physician ____

Hospital____

Medical Alert Information ____

Notary of Public (seal)

On this _________________________________ day of ______________________

Year _______.

Expiration Date: ______________________________