

KIDLIFE PRESCHOOL
AUTHORIZATION FOR MEDICAL TREATMENT

If my child, _____, should become ill or injured at KIDLIFE PRESCHOOL, 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, I authorize KIDLIFE PRESCHOOL 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: _____