



## Emergency Medical Authorization

Should \_\_\_\_\_, \_\_\_\_\_  
Child's Name Date of Birth

suffer an injury or illness while in the care of \_\_\_\_\_  
Facility Name

and the facility is unable to contact me (us) immediately, facility shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: \_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Facility Administrator/Person-In-Charge \_\_\_\_\_  
Signature

Date: \_\_\_\_\_

