

## Child's Emergency Medical Authorization

Name of Child	Birth Date
Name of Parent (s) or Guardian	
Home Address	
Home Telephone #	
Place of Mother's Employment	
Work Address	
Work Telephone #	
Cell Phone #	
Place of Father's Employment	
Work Address	
Work Telephone #	
Cell Phone #	
The parent(s) guardian authorizes <u>VICTORY CHRISTIAN PRESCHOOL &amp; ACADEMY</u> to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to, his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that his agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately. I understand that this form will be taken with my child to the nearest hospital in case of an emergency.	
1. I/we _____ will be responsible for payment of medical care expenses NOT covered by my insurance.	
2. Medical treatment costs are covered by:	
➤ Blue Cross/Blue Shield Policy No. _____	
➤ Medicaid Coverage No. _____	
➤ Other Medical insurance:	
Name of insurance company _____	
Policy No. _____	
➤ No Insurance _____	
Child's physician & telephone #	
Allergies to foods or medication:	
Parent Signature	Date