VISION MONTESSORI

# Child's Emergency Medical Authorization

Name of Child_____ Birth date_____

Name of Parent(s) or Guardian_____

Home Address_____ Telephone #_____

Place of Mother's Employment_____Telephone #_____

Address_____ Cell #_____

Place of Father's Employment_____ Telephone #_____

Address_____ Cell # _____

The Parent(s)/guardian authorizes **Vision Montessori /** Beth Chaverim 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 this 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.

1. I/we will be responsible for payment of medical care expenses._____

2. Medical treatment costs are covered by:

    a. Private Insurance (name & policy no.) _____

    b. Medicaid Coverage No. _____

c. Other medical insurance:

    Name of Insurance Company _____

    Policy No. _____

d. No insurance _____

Child's physician or clinic attended _____

Attached is a copy of the agreement with:

Child's parent(s) or guardian and the day care center operator. Yes_____ No _____

_____ _____

Signature (Parent(s)/Guardian) Date

This form is to be kept by Vision Montessori / Beth Chaverim and is to be taken to the doctor or treatment facility in case of emergency.