# PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

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|---|---|
| Child's Name: | |
| Age: | Date of Birth: |
| Address: | |
| Parent(s) Name: | |

**Child's Medical Information**

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| Medical Problems and Allergies (Please list any medical issues LEAP should be aware of): |
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| Medicine(s) Child is Taking: |
| Medicine(s) Child is Allergic To: |
| Name of Child's Doctor: |
| Doctors Telephone #: |

**Child's Insurance**

| | |
|---|---|
| Name of Insurance Company | |
| Group Number | ID# |

I(we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize LEAP Preschool, LLC's director or director's designee to obtain emergency treatment for my child. I (we) consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

<u>The following steps will be followed in an emergency:</u>

1. The parent/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact you through all of the emergency person's listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all of the following:
    a. Call for emergency first aid assistance/transportation.
    b. Call another physician.
    c. Have the child transported to an emergency hospital in the company of a staff member.

Parent/Guardian Signature: _____ Date:_____