

Carmel Clay Edu-Care Center

EMERGENCY MEDICAL AUTHORIZATION

I agree, and by my signature give consent, that in case of accident/or injury or illness of a serious nature, my child (child's name) _____ will be given emergency
PRINT NAME
medical care. I hereby authorize the physician on duty in the emergency room and whomever he/she designates as his/her assistants to administer such treatment of operative procedures, including anesthetics, as are necessary. I understand that I will be contacted immediately, or as soon as possible should I be away from the numbers given with this application.

**The emergency contact person/s listed on my child's
"Authorization for Child Pick Up" form will be contacted after attempts to
contact me and/or my spouse are unsuccessful and we are not able to be reached.**

If it is within our ability, Edu-Care Staff will seek care at the closest medical facility available. If your insurance "designates a particular hospital", it is your responsibility to make those arrangements once you are able. Please know that with most emergency situations, in calling 911, we are unable to specify the "hospital of choice" as getting immediate care for your child is our primary concern.

Physician's Name _____
PRINT NAME

Address _____ Phone # _____

Dentist's Name _____
PRINT NAME

Address _____ Phone # _____

Parent/Legal Guardian Name _____
PRINT NAME

Parent/Legal Guardian Signature _____

Date _____