AUTHORIZATION FOR EMERGENCY MEDICAL CARE

In the event I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give my permission for: COVENANT PRESBYTERIAN PRESCHOOL & CDO Director or person in charge to care of my child.

Name of Child: _____ Date of Birth: ____/____/____

Name of Parents: _____

THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY!!!!!!!!

HOSPITAL INFORMATION:
Hospital Name: **Dell Children's Medical Center** Hospital's Telephone: **512-324-0000**
Hospital Address: **4900 Mueller Blvd. Austin 78723**

MEDICAL INFORMATION:
Physician's Name: _____ Physician's Telephone: _____
Physician's Address: _____
Medication(s) Taken: _____

HEALTH HISTORY (check all those that apply)

Frequent ear infections ☐ Chicken pox ☐ Measles ☐ Frequent Colds / Sore Throats ☐ Mumps ☐
Sinusitis / Bronchitis ☐ Strep Throat ☐ German Measles ☐ Mononucleosis ☐ Whooping Cough ☐
Insect Stings ☐ Hay Fever, etc. ☐ Heart Defect / Disease ☐ Tuberculosis ☐ Constipation ☐
Poison Ivy/Oak/Sumac ☐ Epilepsy / Convulsions ☐ Polio ☐ Fainting ☐ Bedwetting ☐
Bleeding / Clotting Disorders ☐ Sleep Walking ☐ Asthma ☐ Stomach Problems ☐

MEDICAL INSURANCE INFORMATION:
Insurance Company Name: _____ Insurance Telephone: _____
Insured's Name: _____ Insured Number / Member Id: _____
Group ID #: _____ Employer Name: _____

DENTAL INFORMATION:
Dentist's Name: _____ Dentist's Telephone: _____
Dentist's Address: _____

DENTAL INSURANCE INFORMATION:
Dental Insurance Company Name: _____ Dental Insurance Telephone: _____
Insured's Name: _____ Insured Number / Member Id: _____
Group ID #: _____ Employer Name: _____

I give consent for necessary emergency treatment when my child is in the care of this physician, dentist or hospital. I give permission to transport my child for emergency care.

_____ _____
Signature of Parent or Legal Guardian Date