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 the Covenant Presbyterian Preschool & Child's Day Out Director or person in charge to care for my child.

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

Name of Parents: _____

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