AUTHORIZATION FOR EMERGENCY TREATMENT

I _____ do hereby authorize officials of Trinity
Parent or Guardian
Presbyterian Preschool to contact directly the physicians listed on this form, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of _____.
Child's name

In the event that these physicians or parents cannot be contacted, school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school financially responsible for the emergency care and/or transportation for said child.

_____ _____
Signature Date

DOCTOR:
1st choice-_____ phone# _____

2nd choice-_____ _____ phone# _____

CHILD'S ALLERGIES* _____

MEDICINES CHILD IS TAKING* _____

*EpiPens kept at school must be in the original container with the prescription label attached. A **Written Medication Consent Form** must be completed by the prescribing physician and parent at the beginning of each school year and kept on file with the medication.

OUTSTANDING MEDICAL HISTORY _____
_____
Continue on back if necessary - Check here if so _____

LAST TETANUS SHOT (DTP) _____

INSURANCE COMPANY _____
IDENTIFICATION/POLICY NUMBER_____
SUBSCRIBER'S NAME _____
SUBSCRIBER'S PLACE OF EMPLOYMENT_____

PARENT OR GUARDIAN'S HOME PHONE #_____

MOTHER'S CELL PH#_____WORK PH#_____
FATHER'S CELL PH# _____WORK PH.#_____

WHEN NEITHER PARENT CAN BE REACHED, CONTACT: (preferably local)

NAME: _____ RELATIONSHIP TO CHILD _____
PHONE #'S _____ _____