



**Child Emergency Medical Authorization Form**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Parent(s) or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_ Telephone \_\_\_\_\_

Place of Mother's Employment \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Place of Fathers Employment \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

The parent(s) or guardian authorizes Montessori Children's Center(Name of Licensed Provider) to obtain immediate care and consents to the hospitalization and/or the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to, his/her child if an emergency occurs when he/she cannot be located immediately.

It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

1. I/we will be responsible for medical care expenses  
\_\_\_\_\_

2. Medical treatment costs are covered by:

A. Blue Cross-Blue Shield Policy No. \_\_\_\_\_

B. Medicaid Coverage No. \_\_\_\_\_

C. Other Medical Insurance:

a. Name of Insurance Company \_\_\_\_\_

b. Policy Number \_\_\_\_\_

D. No Insurance Coverage \_\_\_\_\_

Child's Physician or Clinic \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent (s) or Guardian

\_\_\_\_\_  
Date