

EMERGENCY AUTHORIZATION

Preferred Hospital: _____ Phone: _____

Name of Parent's Insurance Co. _____ Policy #: _____

In case of medical/surgical emergency, we hereby authorize any and all necessary tests, procedures, and/or treatment for our son/daughter

(CHILD'S NAME)

when we are not available. We authorize _____
to seek such medical care. (DAY CARE PROVIDER)

Dated: _____ Signed: _____

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