WEECare

PRESCHOOL & KINDERGARTEN

FallCreek CHURCH

EMERGENCY MEDICAL AUTHORIZATION

Whenever my child is involved in a school activity and I am unavailable to provide authorization directly, I do hereby grant to the school director or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, on behalf of my minor child listed. This authorization is valid for the current school year or until such time as I withdraw the authorization.

Child's Name: _____School: __WEECare___
Child's DOB: _____

Parent/Guardian Names:_____

Address:_____
(Street) (City) (State) (Zip)

Mother's Place of Employment:_____
(Phone No.)
Father's Place of Employment:_____
(Phone No.

Doctor Preferred:_____
(Doctor) (Phone No.)
Doctor's Address:_____

Dentist Preferred: _____
(Dentist) (Phone No.)
Dentist's Address:_____

Insurance Company:_____
(Insurance Identification No.)

Important Medical Information

Allergies:_____

Current Medication or Treatments:_____

Previous Operations or Hospital Confinements:_____

Authorized: _____ _____
(Parent or Guardian) (Date)

Train up a child in the way he should go and when he is old, he will not depart from it. –PROVERBS 22:6

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