

St. Aloysius Preschool Emergency Medical Authorization

Child's Name: _____

Child's Birthdate: _____

Child's Address: _____

Family Physician Name: _____

Address: _____

Office Phone: _____

Insurance Carrier: _____

Member Name: _____

Policy number and Group Number: _____

Hospital you prefer: _____

The hospital we will default to is Norton Children's Hospital, 4910 Chamberlain Ln, Lou. KY 40241 (502)446-5000

Are there any known allergies, health or medical conditions that the provider should be made aware of? _____

Specific Instructions regarding Child's Treatment: (on going medications, restrictions for treatment, etc.) _____

Parent/Guardian Consent: I hereby give permission to St. Aloysius Preschool to secure and authorize emergency medical care and/or treatment as above-named child might require while under supervision of preschool staff. I further authorize St. Aloysius staff to administer emergency care/treatment as required until further medical assistance is available. I agree to pay costs contingent of any emergency medical care/treatment for said child as secured or authorized under this consent.

Signature of Parents/Guardians:

Name: _____ Cell Phone: _____

Signature: _____ Date: _____

Name: _____ Cell Phone: _____

Signature: _____

Date: _____