

United Church of Broomfield
KOHL STREET KIDS
825 Kohl Street
Broomfield, Co 80020 303 466-8355 X14

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

CHILD'S NAME _____

Authorization for Emergency Medical Care must be obtained from the parents of each child before the child/children can attend the center.

I/We _____

Signature of parents/guardians

hereby give my/our permission to any person in charge of supervising KOHL STREET KIDS school age program to call a health care professional for medical/dental, emergency or surgical care for my child

_____, should an emergency arise.

Child's Name

It is understood that a conscientious effort will be made to locate the parent/s or guardian/s when emergency action will be taken, all expenses for emergency, medical, and dental, treatment or care will be accepted by the parents/guardians.

It is also understood that in the event of illness or accident that requires immediate attention it will be the decision of the director or staff whether or not 911 will be called first and then the parent/guardian. All expenses for transportation and emergency or health care provided for your child at the center or away from the center is the parent's responsibility. I understand this policy and hereby give authorization for emergency medical care.

(Any person having legal custody of this child must sign this form.)

(It is desirable, when possible, to have parents' or guardians' signatures attested by a notary public when they are granting emergency medical authorization. **Parents need to check with their healthcare facilities and hospitals to see if they require this authorization form to be notarized.**)

Make sure this form is notarized if required.

Parent/Guardian

Parent/Guardian

Date

Date

Primary Doctor Name _____

Phone _____

Dentist Name _____

Phone _____

Hospital Preferred _____

Phone _____

Hospital Address _____

