AUTHORIZATION FOR EMERGENCY CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDIAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDIAL CARE, I AUTHORIZE

East Grand Community Services

TO CONTACT THE FOLLOWING:

PHYSICIAN AND PREFERRED HOSPITAL TO BE USED IN AN EMERGENCY

DOCTOR OR CLINIC NAME	PHONE
PREFERRED HOSPITAL NAME	PHONE

ACKNOWLEDGEMENTS (Please check each box.)

A. ☐ I DO ☐ I DO NOT

give permission for the facility to transport my child.

B. ☐ I DO ☐ I DO NOT

give permission for field trips/excursions. I understand I will be notified in advance when they are planned.

C. ☐ I have received a copy of this facility's policies pertaining to the admission, care and discharge of children.

D. ☐ When my child is ill, I understand and agree that my child may not be accepted for care.

E. ☐ I understand that, before the first day of attendance, I will provide proof of completed immunizations or exemption from immunizations.

PARENT/LEGAL GUARDIAN SIGNATURE	DATE

T-shirt size ☐ Yth small ☐ Yth medium ☐ Yth large ☐ Yth XL ☐ Adult small ☐ Adult medium ☐ Adult large

*** From time to time pictures will be taken of the children in the program and used for fliers, brochures, bulletin boards, etc. We need your permission to take and publish these pictures. Please sign at the bottom and chick if you agree to allow your child to be photographed. Thank you!

☐ Yes, I allow my child_____ to be photographed.

☐ No, please do not photograph or print pictures of my child_____.

Parent/Guardian Signature_____