

## Emergency Medical Authorization

Should \_\_\_\_\_  
Child's name Date of birth

suffer an injury or illness while in the care of Dunwoody Baptist Preschool, the school will attempt to contact a parent for directions as to treatment. In the event a parent cannot be contacted or where in the judgment of the school it would be detrimental to the child to delay treatment, I authorize the school to call 911 for emergency transport of my child to Children's Health Care of Atlanta at Scottish Rite hospital. I understand all costs incurred are at my expense.

I agree to keep Dunwoody Baptist Preschool informed of any incidents requiring professional medical attention involving my child.

My child's primary source of health care is:

\_\_\_\_\_  
Doctor's Name Doctor's phone #

\_\_\_\_\_  
Insurance Policy Name Insurance Policy #

Dentist Name: \_\_\_\_\_ Dentist phone# \_\_\_\_\_

Dental Insurance information: \_\_\_\_\_

Please list any known medical conditions: (i.e., Diabetic, asthmatic, food or drug allergies, etc.)

\_\_\_\_\_

\_\_\_\_\_  
Parent Signature Date

Home Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_