

HOSPITAL EMERGENCY TREATMENT AUTHORIZATION

Child's Name: _____
Insurance Company: _____ Policy# _____
If group policy, give group name and I.D.# _____
Child's physician: _____ Phone# (____) ____-_____

Udder Angles Childcare LLC, its staff or designated agents are hereby authorized to secure emergency medical care for my child(ren) when I/we can not immediately be reached in time of emergency. I/we will be responsible for any and all emergency medical charges incurred. The name, address and telephone number of my child(ren)'s physician is on file with Udder Angles Childcare LLC. I understand that my child(ren) may be transferred to the nearest emergency facility by public safety officers or agents of Udder Angles Childcare LLC.

Mother's Signature

Father's Signature

If either parent is a student, please list name of school, phone and current schedule:

School: _____ Phone: (____) ____-_____
Days/Hours: _____

School: _____ Phone: (____) ____-_____
Days/Hours: _____