

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, should become ill or injured at HARVEST TIME CHILD DEVELOPMENT CENTER, I understand that the facility will:

- (1) contact me immediately and/or
- (2) contact the person(s) I have designated if I cannot be contacted

Should the facility be unable to reach me and/or the person(s) I have designated, Harvest Time Child Development Center is authorized to contact my child's physician and/or arrange for immediate emergency treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

Father's Signature: _____

Mother's Signature: _____

Date: _____

Person(s) designated if I am unable to be reached: _____

Expiration Date: _____

Medical Alert Information: _____

Preferred Physician: _____

Hospital: _____

Notary of Public (seal)

On this _____ day of _____ Year _____