

# Oak Grove Preschool Emergency Medical Authorization

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of Parent(s) or Guardian(s) \_\_\_\_\_  
Home Address \_\_\_\_\_  
Phone Numbers where Parent(s)/Guardian(s) may be reached while school is  
in session: \_\_\_\_\_ or \_\_\_\_\_ or \_\_\_\_\_

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_ authorize  
Oak Grove Preschool to obtain immediate medical care and consent to the  
hospitalization of, the performance of necessary diagnostic tests, and the  
use of surgery on and/or the administration of drugs for my child in the  
event that an emergency medical situation occurs during school hours and  
when I may not be located immediately. It is understood that this  
agreement covers *only* those situations which are true emergencies and only  
if I cannot be reached. Otherwise, I expect to be notified immediately.

- I will be responsible for payment of medical care expenses
- Medical treatment costs for my child are covered by:

Insurance Carrier \_\_\_\_\_  
Policy No. \_\_\_\_\_  
Name of Policy holder \_\_\_\_\_

Child's Physician \_\_\_\_\_  
Physician Phone Number \_\_\_\_\_  
Child's Dentist \_\_\_\_\_  
Dentist Phone Number \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_  
Date \_\_\_\_\_