

Class Day & Time: _____

Participating Parent's Last Name: _____

LITTLE HANDS, A PARENT-CHILD CENTER

EMERGENCY MEDICAL AUTHORIZATION

I / We the undersigned parent/parents of _____ do hereby authorize the below named physician to perform or have performed by any physician or surgeon of his/her choice, at any time, any medical, surgical or anesthetic procedure which said physician may deem necessary for the well-being and reasonable comfort of my said child or children in the event that I / We are not available. I / We agree to pay any hospital expenses incurred thereby. I / We are to be notified at the earliest opportunity thereafter of said procedure.

This medical authorization is being left with the person or persons in charge of my child/children in my absence, who has/have been instructed to contact said physician in the event of illness or injury, and have been further instructed to deliver this medical authorization to him/her. In the event he/she is not available, this medical authorization shall extend to any licensed physician in his/her absence.

Physician's Name _____

Phone _____

Hospital Preference _____

Insurance Carrier _____

In case of emergency please contact:

Spouse/Partner _____

Phone _____

Relative _____

Phone _____

Other _____

Phone _____

Signed _____

Date _____

Signed _____

Date _____