## *EVERY LINE MUST BE FILLED IN AS REQUIRED BY D.C.F.S.

### MEDICAL EMERGENCY

I AUTHORIZE KIDDY GARDEN CHILD CARE STAFF TO TAKE WHATEVER EMERGENCY MEDICAL MEASURES ARE DEEMED NECESSARY FOR THE CARE AND PROTECTION OF MY CHILD_____. I UNDERSTAND THAT THIS MAY INVOLVE TRANSPORTING MY CHILD TO OUR DOCTOR, HOSPITAL, OR CONTACTING OUR RESCUE SQUAD FOR ASSISTANCE.

THE POLICY FOR HAWTHORN WOODS RESCUE IS TO TRANSPORT TO GOOD SHEPHARD HOSPITAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY EXPENSES INCURRED IN A MEDICAL EMERGENCY CONCERNING MY CHILD.

SIGNATURE_____ Date_____

I UNDERSTAND IN A MEDICAL EMERGENCY KIDDY GARDEN CHILD CARE WILL ATTEMPT TO REACH THE PARENT(S). IN THE EVENT WE CANNOT BE REACHED, I AUTHORIZE THE RELEASE OF MY CHILD_____ TO THE FOLLOWING PERSONS:

CHILD'S NAME_____ D.O.B._____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
MOTHER_____ HOME #_____ D.O.B._____
WORK #_____ PAGER #_____ CELL #_____
FATHER_____ HOME #_____ D.O.B._____
WORK #_____ PAGER #_____ CELL #_____

NAME_____ HOME #_____
WORK #_____ PAGER #_____ CELL #_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____

NAME_____ HOME #_____
WORK #_____ PAGER #_____ CELL #_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____

NAME_____ HOME #_____
WORK #_____ PAGER #_____ CELL #_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____

DOCTOR _____ PHONE_____
INSURANCE_____ PHONE_____