Voluntary Registration
Child’s Emergency Medical Authorization
(Model Form)

Name of Child: ______________________________ DOB: __________________

Name of Parent(s) or Guardian: ______________________________

The parent/guardian authorizes ________________________________ to obtain immediate care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to his/her child if an emergency occurs when he/she cannot be located immediately.

It is understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses. _____ Yes _____ No

2. Medical treatment costs are covered by:
   a. Medical Insurance
      Name of Insurance Company: ________________________________
      Identification Number: ________________________________
      Group Number: ________________________________
   b. Medical Assistance Plan: ________________________________
      Identification Number: ________________________________
   c. No Insurance: ______

Child’s Physician: ________________________________
Parent Emergency Contact:
Mother: ________________________________
Contact #: ________________________________
Father: ________________________________
Contact #: ________________________________

Signature of Parent of Guardian ________________________________ Date ________________________________

This form is to be kept by the voluntarily registered family day provider and is to be taken to the doctor or treatment facility in case of emergency.