

**FSA Child Care
EMERGENCY TREATMENT AUTHORIZATION**

Child's name _____ Birth date _____
Address _____ City _____ Zip _____
Mother _____ Home Phone _____ Work phone _____
Father _____ Home Phone _____ Work phone _____

I GIVE PERMISSION FOR MY CHILD TO HAVE:

Yes	No	
_____	_____	First aid and/or emergency medical care
_____	_____	Emergency blood transfusion (When condition is life threatening and parent cannot be reached)
_____	_____	Emergency surgery (When condition is life threatening and parent cannot be reached)
_____	_____	Emergency transportation to nearest medical facility (when condition is life threatening and parent cannot be reached)

EMERGENCY INFORMATION

Doctor's name _____ Address _____ Phone _____
Insurance Company _____ ID# _____
Severe allergies such as bee stings, food etc. _____

Medical alert _____

EMERGENCY TREATMENT AUTHORIZATION

In the case of a serious medical emergency my child _____ may be treated by any physician at the nearest medical facility if there is a life threatening emergency.

Parent's signature _____ Date _____

VALID FOR ONE YEAR FROM THE DATE OF SIGNING