



# Emergency Treatment Authorization

If your child becomes ill or has an accident while attending our program, we will inform you immediately. If we are unable to contact you, we will contact the emergency number that you have provided. In the rare event that we are unable to contact your designated emergency contact, and if the staff feels that your child needs immediate medical care, he/she will be transported to the nearest hospital emergency department. Please sign below to authorize the staff to approve emergency medical treatment that is recommended by medical personnel.

I hereby authorize the staff at Five Rose Lane to access and approve emergency treatment at the hospital for my child if we have not arrived.

Preferred Hospital (Name, Address and Number):

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Parent or Legal Guardian's Name (please print):

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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Parent or Legal Guardian's Signature:

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