



EMERGENCY MEDICAL FORM

I, _____, hereby authorize Cross Road Children's Center, in the event an emergency, to seek medical treatment for my child_____.

Cross Road Children's Center is also authorized to transport my child to the nearest medical facility used by the center, if I cannot be reached. I agree to assume responsibility for payment of any, and all emergency treatment and transportation. I agree to keep Cross Road Children's Center informed at all times of any telephone numbers where a preferred physician or I may be reached.

The emergency procedure will be:

1. Contact parent(s).

Name:	Name:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:

2. Contact person(s) listed as emergency contact(s).

Name:	Name:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:

3. Call emergency medical team if necessary (911).

4. Transport child via emergency medical team to:

Hospital of Choice: _____, or

Nearest Hospital: _____.

5. Transport child to the approved medical provider or hospital:

Hospital: _____

Address: _____

Phone: _____

Physician's Name: _____

6. Insurance Company: _____

Policy #: _____ Group # _____

List any known medical conditions (example: diabetes, asthma, drug allergies etc.)

PARENT'S SIGNATURE: _____

DATE: _____

NOTARY: _____ **SEAL:**

DATE: _____