

A Place To Grow Daycare

Medical Treatment Authorization

I give Margaret Trueb permission to obtain emergency medical/dental treatment for my child, _____.

I also give permission for my child to be transferred by ambulance in cases of medical necessity.

Child's Physician: _____

Phone: _____

Medical Plan: _____

Number: _____

Parent's Address: _____

City: _____

Zip: _____

Home Phone Number: _____

Work Number: _____

Emergency Contact: _____

Relationship to Child: _____

Home Phone Number: _____

Other Phone Number: _____

Parent/ Guardian signature: _____

Date: _____