Children's Garden Montessori School

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

This form accompanies the child to the Emergency Room – please be thorough.

Child's Full Name _____ **Birthdate** _____

Allergies_____ **Diet Restrictions**_____

Current Medications _____

Insurance Company _____ **Policy/Group #**_____

Insured's Name _____ **Employer**_____

AUTHORIZATION FOR EMERGENCY MEDICAL AND SURGICAL CARE

In the event my child is injured in an accident, or becomes seriously ill, and I or my designee(s) cannot be reached, I hereby authorize Children's Garden, or any of its employees or representatives, to arrange for the transportation of my child to a licensed emergency medical care facility to receive prompt treatment. I authorize the medical personnel at the facility to provide such treatment to my child as is indicated by the nature and extent of his or her injury and that is in accordance with the protocols of standard medical practice. I accept financial responsibility for all costs associated with the conveyance of my child and for the treatment provided by the medical care facility to my child.

EMERGENCY CONTACT IF PARENT CANNOT BE REACHED: *(please list in order)*

1. Name_____Relationship_____

   Address _____Phone(s) _____

2. Name_____Relationship_____

   Address _____Phone(s) _____

3. Name_____Relationship_____

   Address _____Phone(s) _____

In case of an emergency, your child will be transported to the nearest Pediatric Emergency Room *(unless otherwise noted.)*

Rocky Mountain Hospital for Children at Rose 4567 E. 9th Ave. Denver, CO 80220 303.320.2121

Preferred Emergency Room_____

Address_____Phone_____

Primary Care Physician _____ Phone_____

Address_____

Dentist_____ Phone_____

Address_____

Parent/Guardian signature_____ **Date**_____

All information must be completed – leave no blank spaces. Insert N/A if no information is available.
Enrollment is incomplete until this form is completed and signed by parent/guardian.

Revised 3/7/23