AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Name of Child: ____

Primary Phone Number: ____

Mother's Cell Phone: ____

Mother's Work Phone: ____

Mother's Place of Employment: ____

Father's Cell Phone: ____

Father's Work Phone: ____

Father's Place of Employment: ____

Relative/Friend to Call **If** You Are Not Available: ____

Relative/Friend's Phone Number: ____

Physician: ____

Physician's Phone Number: ____

In case of an emergency or accident, and in the event that I cannot be reached, I hereby give my permission to the Montessori Learning Center, Inc. to seek emergency treatment for the above named child.

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Signature of Parent/Legal Guardian *Date*