LOVEJOY INDEPENDENT SCHOOL DISTRICT
KIDS 1ST AFTER SCHOOL PROGRAM

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone #
______________________	_______________________	_____________________

Emergency Medical Care Facility	Address	Phone #
_________________________________	___________________	_____________________

I give authorization for the facility to secure any and all necessary emergency medical care for my child.

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Signature – Parent or Legal Guardian

List any special problems that your child may have, such as allergies, existing illness, injuries or hospitalizations in the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of.

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