EMERSON
SINCE 1852
PREPARATORY SCHOOL
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Washington, DC 20036

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Authorization to Provide Emergency Medical Care

Date: _____

I hereby authorize any licensed physician to provide any necessary medical services to my child, _____, in a medical emergency, and I agree to promptly pay said physician his/her fee for rendering services. Signature: _____

The following CONDITION(S) should be noted in rendering medical services:

_____

_____

My child is ALLERGIC to the following medications and/or medical products:

_____

_____

My child is covered by the following MEDICAL INSURANCE:

Insurance Company: _____

Policy Number: _____ Type of Policy: _____

Primary Policy Holder: _____

Notify the following person IN CASE OF MEDICAL EMERGENCY:

Name: _____ Relationship to Child: _____

Cell Phone: _____ Work Phone: _____

Other Phone: _____

Email: _____

Street Address: _____

City: _____ State: _____ Zip _____