



AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Child's Name _____ Date of Birth _____ Sex: M ___ F ___

Parent/Guardian's Names: _____

Address _____
Street City State Zip

Non-Custodial Parent Name: _____

Non-Custodial Address _____
Street City State Zip

Telephone Numbers _____
Home Cell Work

Child's Physician _____ Telephone Number _____

Physician's Address _____

Medical Insurance Name _____

Name of Insured _____ Policy Number _____

Insurance Company Address _____

Telephone Number _____ Group Number _____

Child's Allergies or Existing Conditions _____

I/We, hereby give my/our consent to Little Ones Montessori to seek transportation for my/our child, _____ to the nearest hospital for medical treatment in the event of an emergency. I/We understand that the transportation may be in the form of an ambulance and that I/We will be liable for all transportation, medical, and hospital expenses incurred in this regard.

- I authorize emergency medical treatment
- I authorize transportation to nearest authorized medical facility via ambulance

Parent/Guardian Signature

**STATE OF FLORIDA
County of Volusia**

The foregoing instrument was acknowledged before me this _____ day of _____ who is personally known to me or who has produced as identification and who did not take an oath.

Notary Public

Print, type or stamp Commissioned Name of Notary Public