Good Beginnings School

24194 Millstream Drive, Stone Ridge, VA 201015

CHILD'S EMERGENCY MEDICAL AUTHORIZATION

Name of Child _____ Date of Birth _____/____ /_____

Name of Parent / Guardian _____
Telephone Number(s) _____

The parent(s) / guardian authorizes Good Beginnings School to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to, his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situation which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

I / we will be responsible for payment of medical expenses.

YES _____ (skip to Child's Insurance Information)

NO _____ (List the name of party who is responsible _____)

**Child's Insurance Information:**

**Name of Insurance Company** _____

**Group Number** _____

**Policy Number** _____

**Name and phone number of Policy Holder** _____

**Name and phone number of Physician** _____

**Please list any Allergies:** _____

**Other important medical information** _____

_____

**Signature of Parent(s) / Guardian** Date

Student Picture