Good Beginnings School
11501 Sunrise Valley Dr., Reston, VA 20191
Tel : 703.758.8811
Fax : 703.758.8188

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 of Policy Holder _____

Policy Holder's Telephone Number _____

Name of Physician _____

Please list any Allergy of medical drugs _____

_____

Other important medical information _____

_____

_____

Signature of Parent(s) / Guardian Date