AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child,_____, should become ill or

Injured at, _____, I understand that the

Facility will: (1) Contact me immediately and (2) Contact the person(s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

_____

SIGNATURE RELATIONSHIP DATE

HC CCL 21

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child,_____, should become ill or

Injured at, _____, I understand that the

Facility will: (1) Contact me immediately and (2) Contact the person(s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

_____

SIGNATURE RELATIONSHIP DATE

HC CCL 21