



MEDICAL AUTHORIZATION

I, _____ hereby give my consent to the teachers of Mount Olive
ECEC to call _____, at _____,
(Child's doctor) (Dr. Phone)

or any Doctor for medical or surgical care for my child, _____.

Should an emergency arise, it is understood that a conscientious effort will be made to locate

me or _____, _____,
(Adult other than parent) (Address)

_____, before any action will be taken.
(Phone)

But, if it is not possible to locate me at the time of the necessary emergency medical care, this expense will be accepted by me if not covered by Mount Olive ECEC's insurance policy.

Parent's Signature

Date