

## EMERGENCY TREATMENT AUTHORIZATION

In the event of an emergency in which all attempts to contact all persons responsible for my child are exhausted, I give permission for the staff of Rock Bridge Preschool to make a decision for the treatment of my child.

Drs. Name, address & phone number:
Dentist Name, address & phone number:
Hospital of choice Name, address & phone number:
Insurance Information:  <b>(For emergency purposes, please provide a copy of your child's Insurance card)</b>

\_\_\_\_\_  
Providers Signature

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date