**EMERGENCY, MEDICAL & TRANSPORTATION AUTHORIZATION**

By signing below, the legal parent / guardian does hereby give permission and authorize emergency medical or dental care and/or treatment that might be required while under **MINDS IN MOTION, LLC**’s supervision for children indicated on this form. Program team members may take steps including any or all of the following if they believe an emergency situation exists:

1. Call an ambulance and have the child taken to the emergency unit of a hospital.

2. Call the child’s physician or dentist.

3. Call another physician or dentist.

In the case of an emergency, every effort will be made to notify parents and to contact the child’s physician or dentist immediately. If it is necessary to transport or to have the child transported to a hospital, we will take the child to the nearest hospital or to the child’s physician or parent.

| Emergency Contact and Medical Information for a Child | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  |  | | | M | F |
| Child’s Name | | |  | Date of Birth | | |  | |
|  | | |  |  | | | M | F |
| Child’s Name | | |  | Date of Birth | | |  | |
|  | | |  |  | | | M | F |
| Child’s Name | | |  | Date of Birth | | |  | |
|  |  |  |  |  | | | | |
| **Parent Name**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone**  *Additional Emergency Contact 2 (Name and Phone #) :* | | | | **Address**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email** | | | | |
| Medical Information | | | | | | | | |
|  | | | | | | | | |
| Hospital/Clinic Preference | | | | | | | | |
|  | | | | |  |  | | |
| Physician’s Name | | | | |  | Phone Number | | |
|  | | | | |  |  | | |
| Dentists Name | | | | |  | Phone Number | | |
|  | | | | |  |  | | |
| Insurance Company | | | | |  | Policy Number | | |
|  | | | | | | | | |
| Allergies/Special Health Considerations | | | | | | | | |
| **I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment in an emergency situation. I agree to pay all of the costs and fees for any emergency medical care or treatment for my child as secured or authorized under this consent.**  **This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.** | | | | | | | | |
|  | | | | |  |  | | |
| **Parent’s/Guardian’s Signature** | | | | |  | Date | | |
|  | | | | | | | | |