MAPLE LAWN Montessori
Where Learning Gets Attention

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AUTHORIZATION FOR EMERGENCY TREATMENT

I, _____, hereby authorize any physician member of Howard County General Hospital or other facility as determine by the rescue squad, to render medical treatment which in her/his judgment may be deemed necessary in the care of

_____.

(Child or Dependent)

Child's Date of Birth: _____ Last Tetanus Shot: _____

Child's Allergies (if any):_____

Child's Doctor: _____ Phone #: _____

Family Doctor: _____ Phone #:_____

Medicines Child is taking: _____

Outstanding Medical History (e.g., Diabetes, Heart Disease, etc.)_____

_____

_____

_____

Insurance Information

Insurance Company: _____

Identification #: _____ Policy #: _____

Subscriber's Name: _____Phone #: _____

Subscriber's Place of Employment: _____

Family Information

Mother's First Name: _____Last Name: _____ Mobile #: _____

Home #: _____Business #: _____Email: _____

Address: _____City: _____State: _____Zip: _____

Father's First Name: _____Last Name: _____ Mobile #: _____

Home #: _____Business #: _____Email: _____

Address: _____City: _____State: _____Zip: _____

Parent(s) or Guardian(s) Signature: _____ Date: _____