AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR MINOR CHILD ST. MATTHEW AFTER CARE PROGRAM

I _____and _____
(mother or legal guardian) (father or legal guardian)

of_____ in the Town(s) of_____,
(street address)

County of Hartford, State of Connecticut, are (am) the parent(s) and/or legal guardian(s) of _____,
(child's name)

of_____ Town of_____,
(street address)

County of Hartford and State of Connecticut, who attends Saint Matthew After School Program, 33 Welch Drive, Forestville, CT 06010.

I (We) hereby give my (our) consent to the Director of said school or any authorized official of said school, in the event all reasonable attempts to contact me (us) at _____ or _____
(primary phone number) (secondary phone number)

or a third party/family member at _____ for the administration of any treatment
(alternate phone number)

deemed necessary by Dr. _____ at_____
(preferred physician) (phone number)

or Dr._____ at _____
(preferred dentist) (phone number)

or in the event the appropriate practioner is not available, by another licensed physician or dentist; and the transfer of the named child to _____or any other hospital reasonably accessible.
(preferred hospital)

I understand that whenever possible, I will be notified prior to medical treatment of my child. I understand that I will be notified at the earliest possible time should prior notice prove impossible.

My child is allergic to the following medications and anesthetics:_____

_____.

I understand that I am financially responsible for any expenses for medical care or transportation incurred on my child's behalf.

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE CARRIER		
EMPLOYEE/CARDHOLDER		
POLICY NUMBER		

Signature of Parent/Guardian_____Date_____

Signature of Parent/Guardian_____Date_____