EMERGENCY MEDICAL AUTHORIZATION

______________________________ **CHILD'S NAME**	____________________ **PARENT'S/GUARDIAN'S NAME**
______________________________ **AGE & DATE OF BIRTH**	____________________ **ADDRESS**
______________________________ **INSURANCE COMPANY**	____________________ **POLICY NUMBER**

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become seriously ill or injured while under the supervision of The Learning Academy of College Park, when the parent or guardian can not be reached.

I (parent/guardian) ____________________, authorize that in the event that I or my other emergency contact person is unable to be contacted and my child is seriously injured or becomes seriously ill, he/she may be taken to **Piedmont Fayette Community Hospital located at 1255 Hwy 54 West, Fayetteville GA. 30214, 770-719-7000 in an emergency vehicle.** I also hereby give my consent for the administration of any treatment deemed necessary by the attending licensed physician.

This authorization does not cover major surgery unless the medical opinions of the attending licensed physicians concurring in the necessity of such surgery. Every attempt will be made to contact the parent or guardian to obtain permission prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment will be taken with the child. The Director or Teacher will accompany the child in the event of this emergency.

______________________________ Date	____________________ Signature of Parent or Guardian

I do not give my consent for emergency treatment of my child.

______________________________ Date	____________________ Signature of Parent or Guardian