CURIOUS MINDS LEARNING CENTER
CONTACT AND EMERGENCY MEDICAL RELEASE

MEDICAL AUTORIZATION FORM

CHILD'S FULL NAME:

_____

INSURANCE COVERAGE & NUMBER:

_____

DOCTOR NAME/ADDRESS/PHONE:

_____

_____

LIST ALL ALLERGIES/HEALTH PROBLEMS/NEEDED MEDICATIONS:

_____

_____

AUTHORIZATION FOR MEDICAL TREATMENT

As my child's legal guardian, I hereby give Curious Minds Learning Center and the employees thereof permission to obtain medical treatment for my child _____. I am responsible for the payment of such medical treatment. I authorize personal information needed for the treatment of my child to be released to medical/hospital personnel.

FOR MEDICAL AUTHORIZATION, SIGN HERE:

_____ DATE: _____

Parent/Legal Guardian

_____

Print name