



Emergency Transportation & Treatment Authorization

Date: _____ Child: _____ Gender: M F (circle one)

Date of Birth: _____ Address: _____

Phone: _____ City, ST Zip: _____

Authorization:

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I { grant / decline } (circle one) permission for staff of LPCCC to take my child: _____ (Child's name) to the nearest hospital, medical, or dental facility for treatment for any accident or illness as deemed necessary by the provider. I accept full liability for all treatment and ambulance expenses.

Parent / Guardian Signature	Printed Name	Relationship	Date
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Decline option:

I wish the following action to be taken in the event of a medical or dental emergency:

Parent / Guardian Signature	Printed Name	Relationship	Date
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