East Bay Montessori Training Center

Medical Emergency Authorization

This form must be return to the Academic Director on or before the first Day of attendance.

Name _____ Phone _____

Address _____ birth date _____

City, State & Zip _____

Spouse's Name _____ Phone _____

Spouse's Employer _____ Business Phone _____

Address of Employer _____

Medical Doctor _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Please list two persons to be contacted in the event of an emergency.

Name _____ Relationship _____

Address _____ Phone _____

City, State & Zip _____

Name _____ Relationship _____

Address _____ Phone _____

City, State & Zip _____

(OVER)

East Bay Montessori Training Center

PART I – TO GRANT CONSENT

In the event reasonable attempts to contact _____ (spouse,

parent, etc.) at _____ (phone number) have been unsuccessful, I hereby give my consent for: (1)

Dr. _____ (preferred physician), or

Dr. _____ (preferred physician), or

Dr. _____ (preferred dentist), or in the event the designated

preferred practitioner is not available, by another licensed physician or dentist; and (2)

The transfer to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Please list any allergies that you have or medications that you take:

_____

_____

_____ _____

Date Signature

DO NOT COMPLETE PART II IF YOU COMPLETE PART I

PART II – REFUSAL TO GRANT CONSENT

I do not give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish the instructors / directors of East Bay Montessori Training Center to take no action or:

_____

_____

_____ _____

Date Signature