United Church of Broomfield
KOHL STREET KIDS
825 Kohl Street, Broomfield, CO 80020
303-466-8355 ext. 4

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

CHILD'S NAME ____
Authorization for Emergency Medical Care must be obtained from the parents of each child before the child/children can attend the center.

I/We, ______________________________________, hereby give my/our permission to any person supervising Kohl Street Kids school age program to call a health care professional for medical, dental, emergency or surgical care for my child should an emergency arise.

It is understood that a conscientious effort will be made to locate the parents or guardians when emergency action will be taken. All expenses for emergency, medical, and/or dental treatment or care will be accepted by the parents/guardians.

It is also understood that in the event of illness or accident that requires immediate attention, it will be the decision of the director or staff whether 911 will be called first or the parent/guardian. All expenses for the transportation and emergency or health care provided for the child at the center or away from the center is the sole responsibility of the parent.

I understand this policy and hereby give authorization for emergency medical care.

Any person having legal custody of this child must sign this form. Please check with your health care provider and hospital to see if they require this authorization form be notarized. If required, please have the form notarized before returning. Thank you.

__________________________________ __________________________________
Parent/Guardian Signature Parent/Guardian Signature

__________________________________ __________________________________
Date Date

Primary Doctor and Phone ____

Dentist Name and Phone ____

Preferred Hospital and Phone ____

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Health Insurance Information Insurance Company ______________________________

Policy Holder's Name________________________ Policy Number________________

Customer Service Phone ______________________________