



LEGACY LEADERSHIP ACADEMY

Emergency Medical Authorization Form

2017-18

Child's Name: _____

Child's Physician: _____

Physician's Phone: _____

Child's Dentist: _____

Dentist's Phone: _____

Hospital of Choice: _____

In the case of a medical emergency and when reasonable attempts to contact me, my spouse and my child's emergency contacts have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above mentioned doctors, or, in the event that my child's physician or dentist is not available, by another licensed physician or dentist; and the transfer of my child to any hospital reasonably accessible.

Parent's Name (please print): _____

Parent's Signature: _____

Date: _____

