EMERGENCY MEDICAL / HOSPITAL AUTHORIZATION
APOSTLES LEARNING CENTER

CHILD'S NAME_____DATE OF BIRTH_____

ADDRESS_____HOME PHONE_____

PARENT'S / GUARDIAN'S NAME _____CELL _____

PLACE OF EMPLOYMENY & PHONE_____

PARENT'S / GUARDIAN'S NAME_____ CELL _____

PLACE OF EMPLOYMENY & PHONE_____

IN CASE OF EMERGENCY AND PARENT (S)/GUARDIAN (S) CANNOT BE REACHED, I GIVE PERMISSION FOR APOSTLES LEARNING CENTER TO CALL:

NAME_____ PHONE: _____

RELATIONSHIP TO PARENT/GUARDIAN:
_____

NAME_____PHONE_____

RELATIONSHIP TO PARENT/GUARDIAN:
_____

CHILD'S PHYSICIAN/CLINIC NAME _____PHONE_____

THIS CENTER USES, WHEN NEEDED, CHILDRENS HEALTHCARE OF ATLANTA, 1001 JOHNSON FERRY ROAD,
ATLANTA, GA 30342. PHONE # 404-785-5252.

CHILD'S ALLERGIES/MEDICAL CONDITIONS (e.g. diabetic, asthmatic, other)_____

_____

FREQUENCY AND SYMPTONS:_____

CURRENT PRESCRIBED MEDICATION / DOSAGE___:_____

OTHER SPECIAL MEDICAL NEEDS OR CONDITIONS:_____

NAME OF INSURANCE COMPANY
_____

NAME OF PRIMARY POLICY HOLDER
_____

POLICY NUMBER_____ _____ (Please attach a copy of insurance card)

In the event of an emergency involving my child and Apostles Learning Center cannot get in touch with me, I hereby authorize any needed emergency hospital /medical care. I (we) agree to keep A.L.C. informed of changes in telephone numbers, etc. where I (we) can be contacted.

I (we) further agree to be fully responsible for all medical /hospital expenses incurred during the treatment of my (our) child.

ACCEPTED BY:_____ DATE_____
SIGNATURE OF PARENT/ GUARDIAN

ACCEPTED BY:_____DATE:_____
SIGNATURE OF PARENT/ GUARDIAN

(If the child lives with both parents, both parents must sign this form)
EMERGENCY MEDICAL INFORMATION/NEW CHILD PACKET