AUTHORIZATION FOR MEDICAL TREATMENT

Buckingham United Methodist Preschool
1212 West Buckingham Road
Garland, Texas 75040
972.272.3804

Child's Name ____

Child's Physician ____

Physician's Street Address ____

Physician's City,Zip ____

Physician'sTelephone ______________________ Fax ______________________

In the event that I cannot be reached to make arrangements for medical treatment, I authorize Buckingham United Methodist Church Preschool to administer first aid and/or transport my child to the nearest hospital. I also give consent for necessary medical treatment, including blood products (i.e. plasma, whole blood) from a licensed physician, hospital/clinic, and agree to pay all medical fees involved. I hereby release the said school and its agents from liability for action taken pursuant of this release.

Please list any allergies, illnesses, injures or special needs which affect your child.

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List ongoing medications child is taking: ____

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Signature Of Parent Or Legal Guardian   Date