



Authorization for Emergency Medical Care

If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give permission for: BLESSINGS FROM ABOVE CHRISTAIN CHILD CARE CENTER #1; REBECCA NITSCHKE.

To take my child (or children):

| | |
|----------------------|----------------------|
| Name of Child: _____ | Name of Child: _____ |
| Name of Child: _____ | Name of Child: _____ |

To:

| | |
|-----------------------|------------------|
| Name of Doctor: _____ | Telephone: _____ |
| Address _____ | |

Or To:

| | |
|--|---------------------------|
| Name of Hospital: COLLEGE STATION MEDICAL CENTER | Telephone: (979) 696-0000 |
| Address: 1600 ROCK PRARIE ROAD COLLEGE STATON, TX 77840 | |

I give consent for necessary emergency medical treatment when my child is in the care of this physician or hospital.

Signature of parent/guardian:

Date: