

Serendipity Learning Center Enrollment Record

Medical Authorization

Child's Name: _____ Birthdate: _____

In case of emergency or illness please contact:

____ Mother (Name): _____
work #: _____ cell #: _____ Home #: _____
____ Father (Name): _____
work #: _____ cell #: _____ Home #: _____

Other person/s to contact in case of an emergency or illness:

Name: _____ Relationship to child: _____
Address: _____ Phone #: _____

Name: _____ Relationship to child: _____
Address: _____ Phone #: _____

In the event I can not be reached to make arrangements for emergency medical care at the time of illness or injury, I here by authorize Serendipity Learning Center to take appropriate steps to ensure proper medical attention. I give consent for necessary emergency care when my child is in the care of this physician and/or hospital or clinic.

Name of Physician of Choice: _____
Address of Physician: _____
Phone #: _____

Hospital or Clinic of Choice: _____
Address: _____
Phone #: _____

Parent or Guardian Signature

Date

Parent or Guardian Signature

Date