

EMERGENCY AUTHORIZATION FORM

TO ALL EMERGENCY MEDICAL AND DENTAL CARE GIVING FACILITIES:

This is to certify that *the Davis Center* or anyone acting in behalf has my permission to act as my agent on behalf of my child _____

Born _____, in securing immediate medical or dental services in the event of accident or illness when I cannot contacted.

I accept full responsibility for any necessary expense incurred for the emergency medical or dental treatment of my child, which is not covered by the following: Health Insurance

Company _____

Policy Number # _____

Type of Coverage _____

Medicaid Number # _____

Child's Known Allergies or Physical Condition _____

Signature of Parent/Guardian _____

Print Name of Parent/Guardian _____

Date _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email Address _____

Notary Public Signature _____

Date _____