EASTLAKE MONTESSORI SCHOOL
Health Care Authorization

Child's Name _____

Child's Doctor _____

Doctor's Address _____

Doctor's Phone # _____

Child's Dentist _____

Dentist' Address _____

Dentist' Phone # _____

I, _____, hereby give my permission to Eastlake Montessori School to call a doctor for medical or surgical care for my child _____ should an emergency arise. It is understood that a conscientious effort will be made to locate me or my spouse _____ before any action will be taken, but if it is not possible to locate us, the expense of the medical care will be accepted by us.

Please circle the hospital of your choice, but be aware that, in an emergency, the ambulance driver may opt for another one.

1. North Suburban Medical Center 9191 Grant Street Thornton
2. St. Anthony's North Hospital 2551 W. 84th Avenue Westminster
3. Avista Adventist Hospital 100 Health Park Drive Louisville
4. Other - _____
   (name) (address) (phone)

Parent's Signature _____ Date _____