Medical Authorization

Child Name: _____ Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Phone Number (1st contact): _____

Authorization for emergency care:

I understand that I will be notified at once in case of accident or additional illness symptoms related to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice when necessary.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize Christie Reed, or authorized King's Haven staff to contact the following:

Physician or Clinic Name: _____

Street Address: _____

City, State, Zip Code: _____ Phone: _____

Preferred Hospital Name: _____

Street Address: _____

City, State, Zip Code: _____ Phone: _____

Parent/Legal Guardian Signature: _____

Date: _____ Relationship: _____

Christie Reed
Website: www.kingshaven.weebly.com
1401 S. Market
Holden, MO 64040
Phone Number: (816) 267-2214
Email: kingshaven@mail.com