



Crosby Methodist Weekday School

1334 Runneburg Road, P.O. Box 1385
 Crosby, TX 77532
 281-328-5460

Weekday.school@crosbyumc.org
www.crosbyumc.org

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

_____ Child's Full Name _____ Date of Birth _____

I authorize Crosby Methodist Weekday School to contact the following person(s) in case of a medical emergency and I cannot be reached.

Please be certain that the people listed are within a reasonable distance of the school and would be willing and available to pick up your child in the case of illness or emergency. Weekday School will always attempt to contact parents first. If we are unable to reach you, we will call a person listed below.

Name	Complete Address	Relation to child	Phone number(s)
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In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the director or person in charge to take my child to:

Name of Hospital
Name, address, and phone number of physician

I give consent for Crosby Methodist Weekday School to secure any and all necessary emergency medical care for my child in the event I cannot be reached.

Health Insurance Company _____ Policy/Group Number _____

Name of Primary Insured _____

List any medications your child takes on a regular basis or any existing problems your child may have (such as allergies, existing illnesses, previous serious illnesses, injuries, or hospitalizations) and any other medical information: **If there are none, please state "NONE"**.

_____ Signature of Parent or Legal Guardian

_____ Date