St. Aidan After School Program

510/525 Willis Avenue, Williston Park, NY 11596 516-746-6585 ext. 202/302

AUTHORIZATION CONSENTING TO MEDICAL TREATMENT FOR MINOR CHILD

I, _____, the parent of _____

a minor child who was born on _____ and resides at

_____ in the County of

Nassau in the State of New York, authorize an adult at St. Aidan After School Program to seek emergency treatment for my child. Such treatment includes, but is not limited to examination, X-rays, laboratory tests, medical and surgical treatment, use of medication, anesthetics, sutures, and admission for hospital care should this be necessary when efforts to contact me are unsuccessful. It is understood that such care will be given upon the advice of a duly licensed physician or surgeon.

My family doctor is _____.

Phone Number _____. I authorize that you may call him/her in case of an emergency. Any physician acting in his/her place should be advised that my child has the following allergies_____

Sworn to before me this _____ day of _____20___

_____

Notary Public

_____

Signature of Parent/Guardian