



# Bethel UMC Preschool

## EMERGENCY TREATMENT RELEASE

Child's Name: \_\_\_\_\_

In the event of an illness or accident which requires immediate medical treatment at a time when a parent cannot be located, I give permission for the Director or staff designated by the director of Bethel UMC Preschool to authorize such treatment. I will not hold the center nor medical personnel responsible. This is done with the understanding that every attempt will have been made to contact the parents, the child's physician, and other persons listed for emergency contact.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(parent or legal guardian)

Physician's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

Id Number \_\_\_\_\_

**THIS FORM MUST BE NOTORIZED**