

Emergency Medical Treatment for Minors During School Hours at Harvey Browne Preschool

Child's name _____ Birth date _____

Medications child is taking _____

Allergies (food and drugs) _____

Name of parents / guardians _____

Persons legally responsible for the child

Address _____ Zip _____

Home phone _____ Office phones _____

Mobiles / pagers / other numbers I can be found _____

Someone who will know where to find me _____ Phone _____

Family physician _____ Phone _____

If I cannot be located by the above means, please contact the following persons in the event of an emergency. These persons are also authorized to pick up my child from school:

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____



Accredited by the
National Academy
of Early Childhood
Programs

311 Browns Lane
Louisville, KY 40207

HarveyBrowne
Preschool

telephone 502.895.2577
www.harveybrownepreschool.com

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Health Insurance company _____ Policy # _____

Emergency Treatment Authorization: In case of a medical emergency involving the minor listed above. I request the doctor / dentist / hospital staff to contact me or my spouse at the numbers provided. In the event that my spouse or I cannot be reached, I grant written permission to Barbara Bailey, Director of Harvey Browne Preschool, or her designee to release health information to medical personnel; otherwise it will be kept confidential. I grant written permission to Barbara Bailey or her designee to authorize the appropriate medical / dental / hospital personnel to render emergency medical treatment deemed appropriate if my spouse or I cannot be reached. Children transported in an emergency will be taken to Baptist East Hospital. I (we) agree to pay for the treatment or medication received by said child, and release Harvey Browne Preschool from all claims or liability arising from said emergency medical treatment.

Signature _____ Date _____

Witness _____ Date _____