Community Christian Academy
Preschool & Childcare

LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE

YEAR _____

Child's Name: First	Middle Initial	Last

TO WHOM IT MAY CONCERN:

I_____ (the natural parent or legal guardian) hereby give permission that my child, _____ may be given emergency treatment to include first aid and CPR by a qualified child care staff member at **Community Christian Preschool & Daycare.** I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Date:	Relationship
Place:	**Witness:**
Printed Name:	Date:
Signature:	Place:

Health Care Provider	Dentist
Phone Number	Phone Number
Address	Address

Insurance Policy	Policy Holder
Policy Number	Group Number
Employer of Policy Holder	Employer Address

Allergies	Medications
Preferred Hospital for Emergency Care:	

Emergency Contact Name	Phone Number