



**FAITH LUTHERAN PRESCHOOL  
AUTHORIZATION FOR EMERGENCY ATTENTION AND TRANSPORTATION**

<b>Child's Name:</b>	<b>Date:</b>
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If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give permission for Faith Lutheran Preschool and its staff to take my child: (initial each statement)

<input type="checkbox"/> To the nearest hospital;  _____ initialed	<b>St. David's Georgetown Hospital</b> 2000 Scenic Dr Georgetown, TX 78626 Telephone: (512) 943-3000
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<input type="checkbox"/> The hospital I would like my child to be transported to is:	_____ initialed
Name: _____	
Location: _____	

Yes  No	I authorize Faith Lutheran Church and Preschool, it's employees, administrators, teachers, staff, and/or representatives to engage the services of any licensed physicians, hospitals, emergency medical or paramedic personnel to render emergency medical treatment to my child if deemed necessary at the sole discretion of Faith Lutheran Preschool. <span style="float:right">_____ initialed</span>
Yes  No	I give consent for my child to be transported by emergency medical services (EMS) in the event of an emergency. <span style="float:right">_____ initialed</span>
Yes  No	I agree that I am responsible for all cost incurred in the rendering of such medical treatment to my child while at Faith Lutheran Preschool. <span style="float:right">_____ initialed</span>

X \_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date