

PHELPS MEMORIAL HOSPITAL CENTER
701 North Broadway
Sleepy Hollow, NY 10591-1096

**PHELPS CHILD CARE CENTER, INC.
EMERGENCY MEDICAL INFORMATION**

If your child needs medical or dental attention, you as a parent must give permission. It's the law.

What about the times you can't be reached for permission? In a serious case, a physician contact right away to treat your child. In other cases, a hospital will authorize treatment, but only after making an effort to contact you first. And that can mean unnecessary anxious moments for your child while someone tries to contact you.

You can prepare for any emergency by making sure babysitters know where to reach you while you're away. And for those times when it will be hard to contact you, you can give permission to other adults. Then they can act for you in permitting medical or dental care for your child when you're not available.

This is a legal document. With it, you may appoint other adults to act for you. They may be relatives, friends, teachers, clergy, neighbors – anyone who is over 18 years of age and who can be responsible for your children when you are away from them. It is especially important to prepare this form for the times when you know it will be hard to reach you. For example, when you are out of town, when you know you cannot be reached easily by telephone, etc.

Fill out this form, or one similar to it, and give it to the adult(s) who can be responsible for your child while you are away.

If your child needs medical or dental attention, the responsible adult should present this document to the appropriate person, physician, hospital representative, or dentist. They're ready for emergencies. This form can help you get ready too.

Name of Minor	Birth Date

I/We being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint:

PHELPS CHILD CARE CENTER, INC.	PHONE NUMBER: (914) 366-3232
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To act in my/our behalf in authorizing emergency medical, dental, surgical care and hospitalization for the named minor(s) during the period of my/our absence.

Month	Day	Year	Month	Day	Year

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as emergency medical, dental, surgical care or hospitalization may be required.

Parent/Guardian	Parent/Guardian
Signature Print Name	Signature Print Name
Address	Address
City State Zip	City State Zip
Phone # Date:	Phone # Date:
Witness (print name)	Witness (print name)
Witness Signature Date:	Witness Signature Date:

Hospitalization coverage for the above named minor

Name of Insurance Company or government program:	Identification or Contract number:
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Primary Family Physician:	Phone Number:
Physician Sub-specialist:	Phone Number: