# Authorization For Medical Treatment

The Employees of Great Beginnings are committed to the provision of a safe environment for your child. Accidents do occur however, and children do become ill. Therefore, it may become necessary to have your child medically treated.

In the case of emergency, I ________________________, the parent or legal guardian of ________________________, do hereby consent for the medical treatment of my child, and hold Great Beginnings harmless of any injury/illness. I understand that I am responsible for such treatment.

Insurance Company:_____________________________________

Policy or Group Number:_________________________________

Parent / Guardian Signature:_____________________________

State of Florida, County of ________________________
The foregoing instrument was acknowledged before me.
This ______ day of ___________, 20___, by_____________,
who is personally known to me or who has produced
____________________________as identification.

________________________________________ Notary Public
Signature of Notary

________________________________________
Name of notary typed, printed or stamped