EMERGENCY MEDICAL AUTHORIZATION FORM

As parent or legal guardian of the undersigned child, a minor, I hereby give my consent, authorization and permission to The Bell Center for Early Intervention Programs and its agents, servants, volunteers and employees for: The administration of any emergency medical treatment deemed necessary by ______________________________ (preferred physician) or _______________________________________ (preferred dentist), or, in the event the designated preferred practitioner is not available, by any other licensed physician, dentist, or medical personnel; and also for the transfer of the undersigned child to any hospital or medical treatment facility reasonably accessible. I will be responsible for any medical or hospital fees or costs associated with the illness or treatment of this minor in accordance with the terms of this authorization, and the terms of the "Full Release and Waiver of Liability" executed by me with respect to the undersigned child are incorporated fully herein by reference to the same.

Done this ________ day of ____________________, 20__.

____
Name of Child

______________________________ ______________________________
Witness Signature of Parent/Legal Guardian