



**Authorization For Treatment of Minor Children
In The Absence of Parent**

I/we, parent(s) of the following minor child, authorize All About Learning to act in my/our behalf in case my /our child is a victim of accident, injury, or illness when immediate medical or surgical care is needed, provided AAL makes diligent effort first to notify me/us of the situation and obtains my/our preferences and consent. If such efforts to get in touch with me/us are unsuccessful, I/we authorize All About Learning to take such action and give such consent on my/our behalf as their judgment dictates.

I/we understand that we are responsible to have health insurance coverage on our child(ren) and r we are responsible to cover the entire expense of any incidence occurring to our child. All About Learning insurance does not cover the cost for incidents that occur to children while in our care, unless it is due to the negligence of the staff.

I/we prefer that the following physicians treat our minor children:

_____ Name _____ phone

_____ Address of office

Preferred Hospital: _____

Hospital Phone number: _____

If the above physician or hospital is not available or recommended, I/we authorize AAL to select a physician and hospital to provide treatment.

Name of minor child: _____

Birth date: _____ Date of last DTP _____

HealthCare Plan: _____

Insurance Carrier: _____

Primary Name Insurance is under: _____

Group # _____

Insured # _____

Phone # _____

Signed: _____ Date: _____

Parent or legal guardian

(Please attach a copy of both sides of the insurance card.)

