MEDICAL AUTHORIZATION and RELEASE

I hereby authorize/release the Teachers and Director of Mother's Day Out to obtain any necessary medical treatment for my child, _________________(full name) provided the person or persons involved act in good faith to secure any help or treatment my child may require.

My hospital preference is ___________________________. I understand that if I do not indicate a preference that the hospital of choice for Mother's Day Out is Milwaukee County Children's Hospital.

I further understand that the procedure practiced by the staff of Mother's Day Out in the event of an emergency is as follows:

Major Injury/Illness (including but not limited to seizures, substantial loss of blood, convulsions, not breathing, etc.)

Teacher or Director calls 911.
Child is stabilized according to directions from emergency personnel.
Parent is contacted.
If parent can not be contacted, emergency contact person will be called.

Serious Injury (including but not limited to broken bones, need for stitches, etc.)

Child is stabilized.
Parent is contacted.
If parent can not be contacted, the emergency contact person will be notified.
Teacher/Director follows instructions given by parent or emergency contact person.

Mother's Signature__________________________________Date_________

Father's Signature___________________________________Date_________