

**JSU CHILD DEVELOPMENT CENTER at McCLELLAN**

**Emergency Medical Authorization**

In the event should \_\_\_\_\_, \_\_\_\_\_ suffer an  
(Child's Name) (Date of Birth)  
injury or illness while in the care of Jacksonville State University Child Development Center and Jacksonville State University Child Development Center is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as deemed necessary. I (we) shall assume responsibility for payment of services.

I (we) agree to keep Jacksonville State University Child Development Center informed of changes in requiring professional medical attention involving my child.

Mother/Legal Guardian's Name \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

Cell # \_\_\_\_\_ Beeper # \_\_\_\_\_

Father/Legal Guardian's Name \_\_\_\_\_

Work # \_\_\_\_\_ Home # \_\_\_\_\_

Cell # \_\_\_\_\_ Beeper # \_\_\_\_\_

Child's primary source of health care is

\_\_\_\_\_  
Physician/ Clinic Name Telephone

Known special needs and/or medical conditions (i.e., Diabetes, Asthma, Drug Allergies, Seizures):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Signature (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_