A Children's Studio
achildrensstudio@gmail 760-292-5040 www.AChildrensStudio.com

AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT
(CUSTODIAL PARENT)

I, _____ do hereby authorize the professional Supervised Provider/Monitor to obtain emergency medical treatment for the child(ren), if necessary.

CHILD(REN)'S NAMES

_____
_____
_____
_____

ANY EXISTING MEDICAL CONDITIONS OR ALLERGIES:

_____
_____
_____
_____

_____
Physician's Name

_____
Physician's Telephone Number

_____
Parent's Signature

AUTHORIZATION FOR EMERGENCY CONTACT
(CUSTODIAL PARENT)

I, _____ authorize my emergency contact to be called if the visitation supervisor considers it necessary. I release the monitor from all claims, I assume all risk for claims which may arise as a result of acts or omissions by the following emergency contact person.

Who should be called if you are not available and an emergency happens?

_____
Name

_____
Address

_____
Phone Number

_____
Relationship to Custodial Parent

***Please attach copy of California Driver's License or other photo ID**

Emergency Contact persons are expected to be familiar with rules and procedures, and monitors reserve the right to refuse to work with anyone who is disruptive to visitation services.

_____
Signature of Custodial Parent

_____
Date