Medical Communication Authorization

I authorize my health care provider to have two-way communication with Jessica Eastman of Peace of Mind Playschool in the event of a medical illness or emergency when I cannot be reached.

Childs' name: _____ Date of Birth: _____

Parent's Name: _____

Parent's Signature: _____

Health Care Provider Name: _____

Health Care Provider Signature: _____

PLEASE MAKE SURE YOUR CHILD'S HEALTH CARE PROVIDER KEEPS A COPY OF THIS FORM ON FILE