

Edgewood Children's Center  
330 North Gore Avenue  
Saint Louis, MO 63119

**Respite Services  
Emergency Health Care Authorizations Form**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

1. Emergency Medical Treatment, Dental Care and Hospitalization.

I hereby authorize and grant permission for emergency medical treatment, emergency dental care, and emergency hospital admission for the above named child who is receiving services from Edgewood Children's Center, when such services are deemed necessary and advisable by duly qualified medical/dental personnel. Edgewood Children's Center will attempt to contact me before any such services are obtained and I will be informed of the services obtained as soon as I can be reached.

_____	_____	_____
Doctor Preferred	Address	Phone
_____	_____	_____
Hospital Preferred	Address	Phone
_____	_____	_____
Dentist Preferred	Address	Phone
_____	_____	_____
Medical Insurance Plan	Policy/Group Number	Medicaid Number

2. Medication Administration

I hereby authorize and grant permission for qualified Edgewood Children's Center personnel to administer to the above named child, who is receiving services from Edgewood Children's Center, medications prescribed by a duly qualified physician and non-prescription medications as needed. I will inform Edgewood Children's Center of all medications prescribed for the child and of any medications to which the child is known to be allergic.

Drug Allergies \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to child \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature/Degree/Title