

**06-21-05G**

**AUTHORIZATION FOR EMERGENCY TREATMENT OF A CHILD**

In the event of a medical emergency involving

*(name of child)*

I understand that Community Living Toronto will attempt to contact me or my physician

*(name of physician)*

If, after making a reasonable attempt to do so, the Association is unable to contact either myself or the physician above, I hereby authorize the Association, or a physician selected by the Association, to secure proper treatment, including hospitalization, for the above child.

This child is covered under Health Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates this \_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 \_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent or Guardian

Please complete and return this form to the appropriate program Supervisor/Manager.