



Medical Release Form  
Celebration Preschool  
2024-2025

In the event that I or my child's pediatrician cannot be reached to make arrangements for emergency medical attention, I authorize Celebration Preschool staff to have my child \_\_\_\_\_, transported to the emergency room of the nearest hospital. I also authorize the hospital and the medical staff of the hospital to administer treatment considered necessary for the well-being of our child. We will assume full financial responsibility for the cost of the ambulance and/or for treatment administered at the hospital.

Please list any medical information for your child that will be beneficial to the hospital and doctors administering care.

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Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Insurance Information**

Insurance Company \_\_\_\_\_

Name of Insurer \_\_\_\_\_

Policy Number \_\_\_\_\_

**Pediatrician**

Doctor's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Where is your child's doctor on staff? \_\_\_\_\_