LEAPFROG LEARNING CENTER Inc.

Medical Authorization Form

Child's Name_____ Home Phone #_____

Home Address_____

DOB _____ Allergies_____ Medication_____

Mother's Name_____ Social Security Number _____

Cell Phone # _____ E-Mail _____

Mother's Employer_____ Business Phone #_____

Father's Name_____ Social Security Number _____

Cell Phone # _____

Father's Employer_____ Business Phone #_____

Names of friends or relatives to be called if you can't be reached in an emergency:

1._____ Phone #_____

2._____ Phone #_____

Physician to be called in an emergency:

1._____ Phone #_____

Full names of all persons authorized to take your child from the Leapfrog Learning Center.

1. _____

2. _____

3. _____

AUTHORIZATION

I authorize members of the Leapfrog Learning Center Inc. staff to take whatever emergency medical measures deemed necessary for the protection of my child while he/she is in the care of the Leapfrog Learning Center Inc. I understand that this authorization includes approval to call the physicians named above, transporting my child to the emergency room of a hospital, and approving emergency medical treatment (if such treatment is deemed necessary by the attending physician).

Signed:_____ (Relationship_____)
Signature of Parent or Legal Guardian

Please Print Full Name:_____ Date:_____