

Emergency Medical Authorization

Emergency Medical Care Policy

In a medical emergency situation, Bloom Children's Center will make all possible efforts to reach the parents/guardians of the child. The child will be transported to :

St Charles Medical Center
2500 NE Neff Road
Bend, Oregon 97701
(541) 382-4321

Medical Emergency Authorization:

-I authorize Bloom Children's Center to transport my child in the case of a medical emergency, including but not limited to use of an ambulance when Bloom staff deem necessary. _____

(initial)

-I also authorize Bloom Children's Center to secure emergency medical and/or surgical treatment from a licensed physician and/or hospital for my child, should such be necessary. _____

(initial)

-I understand that all reasonable efforts will be made to notify me before such action is taken and agree to accept that which is the result of such emergency care. _____

(initial)

Signed _____ Date _____
(parent/guardian)

For _____
(child 1)

(child 2)

(child 3)