



Emergency Medical Treatment

I, _____, in the event that I cannot be reached to make arrangements for
(Name of parent or guardian)
emergency medical attention, authorize the staff or coaches of Pirouettes of Texas, Inc., to transport my child,
_____, to Dr. _____, or (hospital)
_____ or the nearest emergency medical facility. If our physician is not available, I authorize the
staff/coaches to obtain emergency medical attention and treatment for my child at the hospital/clinic of their choice, and I give
consent to the hospital/clinic and physicians to render the necessary emergency treatment to my child.

(Signature of Parent or Guardian)

(Date)

(Signature of Witness)

(Date)

Insurance Company: _____ Policy Number: _____

Group Number: _____ Name of Insured: _____

Known Drug Allergies: _____

Emergency Phone Numbers: _____
(Work) (Home) (Friend)

The above information is important to ensure treatment and reimbursement of expenses incurred when parents are unavailable.