

**HOSPITAL FORM**  
**Apostles Child Development Center**

I give permission to Apostles Child Development Center to have the nearest available hospital administer emergency treatment to \_\_\_\_\_ in the event that the need should arise.

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Parent/Guardian's Signature

Date

Parent's/Guardian's Work Phone:

Mother's Name \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Place of Employment: \_\_\_\_\_

Guardian's Name \_\_\_\_\_ Work Phone: \_\_\_\_\_

Guardian's Place of Employment: \_\_\_\_\_

Child's Birth date: \_\_\_\_\_