

Baby House
3502 Easter Stanley Road
Tallahassee, Florida 32308



Preschool
3519 Easter Stanley Court
Tallahassee, Florida 32308

www.thelearningpavilion.org
P: (850) 921-KIDS(5437)
F: (850) 921-4734

EMERGENCY MEDICAL AUTHORIZATION & DEVELOPMENTAL SCREENING

Emergency Medical Authorization

I (We) _____ and _____
Parent/Guardian Parent/Guardian

of _____
Street City State Zip Code Country

do hereby state that I am (we are) the parent(s) or legal guardian(s) having legal custody of

_____, born _____
Child's Name Birth Date

who resides with me (us) at the address listed above, do authorize the Director or any employee of The Learning Pavilion to consent to any x-ray examination, anesthetic, medical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the State of Florida when such treatment is immediate, and when efforts to contact me (us) are unsuccessful.

Hospital Preference: Tallahassee Memorial Hospital Capital Regional Medical Center

Child's Doctor: _____ Phone Number: _____

Parent's Doctor: _____ Phone Number: _____

Developmental Screening

I acknowledge that throughout my child's enrollment he/she will receive developmental screenings for the purpose of ensuring the optimum learning environment for my child's development. These screenings will be performed by your child's teacher, as well as Therapy Staff (Speech, Occupational, Physical, Behavioral Therapists). I understand that the results will be shared with me and I will have ample opportunity to discuss further evaluation and am an integral part of setting goals and tracking developmental progress.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The forgoing instrument was acknowledged before me this _____ day of _____, 20____.

Print, Type of Stamp Name of Notary

_____ Personally Known

_____ Or Produced Identification

_____ Type of ID and ID# _____