



First Friends Enrollment Form

FBC Prosper

Amy Newton, Director

Name of Child: _____ DOB: _____

MEDICAL TREATMENT AUTHORIZATION

I, _____, give First Friends permission to obtain emergency medical treatment for my child. If the physician listed below cannot be reached, permission is granted for another licensed physician to be called.

Child's Physician _____ Physician's Phone _____

Address _____

Hospital Preference _____ Address & Phone _____

Medical Plan _____ Group Number _____ Policy Number _____

Allergies & Medical Needs

Allergies: _____
List any special needs: _____

Signature of Parent: _____

Date: _____