

HOLY TRINITY PRESCHOOL  
740 Tiffin St. Bucyrus, OH 44820

EMERGENCY TRANSPORTATION AUTHORIZATION

Name of Child/Children*		
Address		Phone
Mother's (or Guardian's) Name	Address	Phone
Employer's Name	Address	Phone
Father's (or Guardian's) Name	Address	Phone
Employer's Name	Address	Phone

\* Names of additional children from the same family may be listed here when all other information on this form pertains to all children listed.

If not at home or work, give the school a telephone number or other number where parents can be reached.

Mother (or Guardian) \_\_\_\_\_ Father (or Guardian) \_\_\_\_\_

People to be contacted in the event of an emergency if the parent cannot be reached:

Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Relationship to Child	Phone	Relationship to Child	Phone

Name of Physician or Clinic		Name of Dentist or Clinic	
Address		Address	
City, State, Zip	Phone	City, State, Zip	Phone

(OVER)

COMPLETE EITHER PART I OR PART II BELOW.  
DO NOT COMPLETE BOTH.

PART I. PERMISSION TO TRANSPORT CHILD

I give **Holy Trinity Preschool** my permission to transport my child/children  
\_\_\_\_\_ to \_\_\_\_\_ for  
Name of Child/Children Hospital or Clinic  
emergency care or to \_\_\_\_\_ for  
Dentist or Clinic  
emergency dental care or to the nearest available source of assistance.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

PART II. REFUSAL TO GRANT PERMISSION TO TRANSPORT CHILD

I do not give permission to **Holy Trinity Preschool** to transport my  
child/children \_\_\_\_\_ for emergency medical or  
Name of Child/Children  
dental care. In the event of an illness or injury which require emergency medical  
or dental treatment, I wish the following action to be taken: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date