

# EARLY CHILDHOOD & EXTENDED CARE STUDENTS ONLY!! 1 PER STUDENT

## PARENTAL EMERGENCY MEDICAL CONSENT

**This form must be presented upon admission for treatment**

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist. School Personnel have permission to access my child's health information.

I agree to pay all costs and fees as secured or authorized under this consent.

<b>CHILD'S NAME:</b>		<b>BIRTH DATE:</b>	
<b>PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES</b>			
<b>1. NAME</b>		RELATIONSHIP TO CHILD	
ADDRESS		EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER	
<b>2. NAME</b>		RELATIONSHIP TO CHILD	
ADDRESS		EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER	
<b>EMERGENCY CONTACT PERSON(S)</b>			
<b>1. NAME</b>		RELATIONSHIP TO CHILD	
HOME NUMBER		CELL NUMBER	WORK NUMBER
<b>2. NAME</b>		RELATIONSHIP TO CHILD	
HOME NUMBER		CELL NUMBER	WORK NUMBER
<b>3. NAME</b>		RELATIONSHIP TO CHILD	
HOME NUMBER		CELL NUMBER	WORK NUMBER
<b>PERSONS AUTHORIZED TO PICK UP CHILD</b>		<b>ADDRESS</b>	<b>PHONE NUMBER</b>
1.			
2.			
3.			

*Is there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?*

<b>Name</b>	<b>Name</b>
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<b>PHYSICIAN NAME</b>		<b>DENTIST NAME</b>	
PHONE NUMBER		PHONE NUMBER	
ADDRESS		ADDRESS	
<b>HOSPITAL PREFERENCE</b>			
<b>KNOWN ALLERGIES</b>			DATE OF LAST TETANUS
PRESENT MEDICATION			
INSURANCE COMPANY		POLICY HOLDER ID	

**This consent will be in effect for one year beginning (date) \_\_\_\_\_**

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

\_\_\_\_\_  
DATE