Emergency Medical Treatment Authorization

Permission for medical care in parental absence.

Child's Full Name_____ Birth Date_____

Name child answers to:_____

I, _____ parent or guardian of the child named above give my permission to _____, child care provider, to secure and authorize such emergency medical care and treatment as my child might require while under the Provider's supervision. I also authorize the Provider to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all the costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents <u>immediately</u> in case of emergency. In the event of an emergency, it would be necessary to have the following information:

Name of Parent or Legal Guardian:_____
Address:_____
Home Phone:_____ Work Phone:_____

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Address:_____
Home Phone:_____ Work Phone:_____

Doctor:_____
Doctor's Address:_____
Doctor's Phone:_____

Preferred Hospital to Contact:_____
Address:_____ Phone:_____

Dentist:_____
Dentist's Address:_____
Dentist's Phone:_____

Persons to be contacted in emergency <u>if the parents are unavailable</u>:

<u>Name</u>	<u>Home Phone</u>	<u>Work Phone</u>	<u>Relationship</u>

Present medication(s):_____
Known allergies:_____
Date of last tetanus:_____ Religious Preference:_____
Insurance:_____

Father's signature:_____ Date:_____

Mother's signature:_____ Date:_____