

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

CHILD'S NAME _____

Age _____ Date of Birth _____

Address _____

PARENT(S) NAME _____

Parent(s) Address _____

CHILD'S MEDICAL INFORMATION

Medical Problems _____

Allergies
Medicine(s) Child is Taking _____

Medicine(s) Child is Allergic to _____

Name of Child's Doctor _____ Phone _____

CHILD'S INSURANCE

Company/HMO _____

Group Number _____ Identification # _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above child care center director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in an emergency:

1. The parent/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact you through all of the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all of the following:
 - a. Call for emergency first aid assistance/transportation
 - b. Call another physician
 - c. Have the child transported to an emergency hospital in the company of a staff member.

Parent Signature: _____

Date of Signature: _____ Date Permission Terminated: _____

Witness: _____ Date: _____