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.

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

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

Are 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?

Name	Name				
PHYSICIAN NAME	DENTIST NAME				
PHONE NUMBER	PHONE NUMBER				
ADDRESS	ADDRESS				
HOSPITAL PREFERENCE					
KNOWN ALLERGIES		DATE OF LAST TETANUS			
PRESENT MEDICATION					
INSURANCE COMPANY	POLICY HOLDER ID				
This services will be in offect for one was beginning (date)					

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

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

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