CONSENT FOR EMERGENCY MEDICAL TREATMENT -

Child Care Centers or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Center for Child and Family Studies TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
CHILD'S FULL NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES: _____

_____

_____

PHYSICIAN AND/OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	**ADDRESS**	**TELEPHONE**	**MEDICAL PLAN AND NUMBER**
DENTIST	**ADDRESS**	**TELEPHONE**	**DENTAL PLAN AND NUMBER**

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN _____

_____ _____

DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

Home Address	
Home Phone ( )	Work Phone ( )