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 home 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: _____

Persons to be contacted in emergency if the parents are unavailable:

Name	Home Phone	Work Phone	Relationship

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

Father's signature: _____ Date: _____

Mother's signature: _____ Date: _____