

PARENTAL EMERGENCY MEDICAL CONSENT
This form must be presented upon admission for treatment.

Child's Full Name _____ Date of Birth _____

This form allows parents and guardians to authorize the provision of emergency treatment for above 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 me at _____(phone number) or _____ (phone number) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor _____ (physician) at _____ (phone number) or Doctor _____ (dentist) at _____ or in the event the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to _____ (preferred hospital).

1. Parents/Guardians/Custodians with Whom the Child Resides:

• Name _____ Relationship to Child _____
 Address _____ Home Phone _____ Cell Phone _____
 Employer _____ Email Address _____
 Work Phone _____ Work Hours _____

• Name _____ Relationship to Child _____
 Address _____ Home Phone _____ Cell Phone _____
 Employer _____ Email Address _____
 Work Phone _____ Work Hours _____

2. Persons to Contact In Case of Emergency if Parents Are Unavailable, and are Authorized to Pick Up Child:

• Name _____ Relationship to Child _____
 Address _____ Home Phone _____ Cell Phone _____
 Employer _____ Email Address _____
 Work Phone _____ Work Hours _____

• Name _____ Relationship to Child _____
 Address _____ Home Phone _____ Cell Phone _____
 Employer _____ Email Address _____
 Work Phone _____ Work Hours _____

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 _____

4. Information:

Physician name _____	Dentist name _____
Street address _____	Street address _____
City, State _____	City, State _____
Phone # _____	Phone # _____

Date of Last Tetanus _____ Known Allergies _____

Present Medication _____

Insurance Company _____ Policy Holder's I.D. _____

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

Signature Parent/Guardian _____ Date _____ Signature Parent/Guardian _____ Date _____