Plainview Nursery School

Child's Name_____ Birth Date _____ Class _____

Authorization for Emergency Medical Treatment

_____

Parent's Name | Address | Home Telephone Number

_____

Child's Physician | Address | Telephone Number

Date of Last Tetanus Shot (DTaP) _____ (This date can be found on your child's immunization record)

Allergies - Medications_____ Allergies - Food/environment _____

If my child should require medical attention due to accident, illness or injury during school hours, and neither his parents nor the family physician can be reached, I hereby authorize the Plainview Cooperative Nursery School to have emergency treatment administered at the time by a physician available to the school or at the Emergency Room of the nearest Hospital.

_____ _____

Parent's Signature Date

Mother's Name _____ Work # _____ Cell # _____

Father's Name _____ Work # _____ Cell # _____

Person to be Contacted in Case of Emergency (if parent is not available)

_____

Name | Telephone Number | Relationship

_____

Name | Telephone Number | Relationship

On _____, before me personally, came _____, to me known, and known to me to be the individual described in and who executed the foregoing Authorization for Emergency Medical Treatment and duly acknowledged to me that he/she executed the same.

_____

Notary Signature