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
3. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER

PERSONS AUTHORIZED TO PICK UP CHILD	**ADDRESS**	**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 consent will be in effect for one year beginning (date) _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

SIGNATURE OF PARENT OR GUARDIAN **DATE**