Parental Emergency Medical Consent
This form must be presented upon admission for treatment

Child's Full Name_____ **Date of Birth** _____

Parents/Guardians/Custodians with whom the child resides:

Name: _____ Relationship to Child: _____
Address: _____ City/Zip: _____
Employer: _____ Department: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Name: _____ Relationship to Child: _____
Address: _____ City/Zip: _____
Employer: _____ Department: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Person to contact in case of emergency if parents are unavailable, and are authorized to pick up child:

Name: _____ Relationship to Child: _____
Address: _____ City/Zip: _____
Employer: _____ Department: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Name: _____ Relationship to Child: _____
Address: _____ City/Zip: _____
Employer: _____ Department: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

I, _____ parent or guardian of the child named above give my permission to Good Shepherd Center to secure and authorize such emergency medical care, emergency dental care and treatment as my child might require while under the Center's supervision. I also authorize the Center 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.

Doctor: _____ Doctor's Phone:_____
Doctor's Address: _____
Preferred Hospital to Contact: _____

Dentist:_____ Dentist's Phone: _____
Dentist's Address_____

Known Allergies: _____
Current Medications: _____
Insurance Company and Policy Number: _____

_____ _____
(Signature of Parent) (Date) (Signature of Parent) (Date)

GOOD SHEPHERD CENTER
603 GREENWOOD DR.
IOWA CITY, IA 52246
319-338-0763

PICK-UP PERMISSION FORM

I hereby give permission for my child to leave the center with the following persons named below.
It is the responsibility of the parents to notify the center, in writing, of any changes.

Name of Child _____

NAME	RELATIONSHIP	PHONE NUMBER

If there is a separation or divorce custody problem of which we should be aware, please explain:

_____
_____
_____

Name of persons who may not pick up your child:

_____

_____

_____ X _____

Date Signature of Parent or Guardian

GOOD SHEPHERD CENTER
603 GREENWOOD DR.
IOWA CITY, IA 52246
319-338-0763

Name of Child_____

Travel and Activity Authorization

I_____ give my permission _____do not give my permission **(check one)** for my child to leave Good Shepherd Center in a car driven by an authorized teacher or parent driver or to take public transportation accompanied by authorized teachers for scheduled field trips. (Please note that you will be notified in advance of the scheduled field trips and asked to initial a permission slip.)

I ____give my permission _____I do not give my permission **(check one)** for my child to go on neighborhood walks or to area parks with authorized teachers.

Picture Release

I ____give my consent _____do not give my consent **(check one)** to let my child be photographed for use at Good Shepherd Center. (For example: in classrooms, on birthday boards, class projects, etc.)

I____ give my consent ____ do not give my consent **(check one)** to let my child be photographed for use on Good Shepherd Center's website, www.gsckids.org/www.gsckids.com.

I ____give my consent ____ do not give my consent **(check one)** to let my child be photographed for use on Good Shepherd Center's Facebook.

This does not grant Good Shepherd Center, or the staff, permission to post pictures on personal or public media, including but not limited to social media outlets: Facebook, Twitter, SnapChat, Tumblr, or any other personal webpage.

_____ X _____

(Date) (Signature of Parent or Guardian)

Good Shepherd Center
603 Greenwood Drive
Iowa City, IA 52246

Allergy Statement

Child's Name _____
Parent Name_____

Parent Signature _____ Date: _____
(for permission to release information)

Nature of allergry_____
_____

Foods Child is Allergic to | Substitute Foods

_____
_____
_____
_____
_____
_____

Does this child have a lactose intolerance that requires a dairy replacement/supplement?
_____

Date for a re-check or re-evaluation _____

Health Care Provider _____
Address _____
_____
Phone_____

_____ _____
Signature of Health Care Provider Date

Over the Counter Medication Permission

Please check off the boxes of the over the counter medications that you wish to give Good Shepherd Center permission to use with your child.

☐Diaper Cream (Provided by parents)

☐Sunscreen (over the age of 6 months) GSC will provide SPF 50 or higher for all children. If a parent chooses, they may bring a specific kind for their child.

☐Lotion (Provided by parent in the case of chapped hands, eczema, ect)

☐Triple Antibiotic Ointment (Provided by GSC)

☐Benadryl Itch Relief Spray (Provided by GSC)

Any notes or special instruction:_____

_____

_____

_____

_____ _____

Parent Signature Date

Parent Information Booklet Permission

I _____ give my permission to
Good Shepherd Center to use my information in the Parent Information Booklet.

Names_____
Child(ren)_____
Email address(es)_____
_____
Phone Numbers _____

_____ _____
(Signature) (Date)