Little Hands & Feet Day Care

1270 BAYRIGE PARKWAY, BROOKLYN, NY 11228
PHONE: 718 680 5437; FAX: 718 680 2757

EMERGENCY MEDICAL AUTHORIZATION

I, ____________________ parent/guardian of _________________, date of birth being________________, do hereby give permission to **Little Hands and Feet Day Care**, to secure and authorize such emergency medical care and/or treatment as above-named child might require while under the supervision of said Childcare Provider. I further authorize said childcare provider to administer emergency care/treatment as required, until medical assistance is available. I also agree to pay all costs and fees contingent of any emergency medical care and/or treatment for said child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it will be necessary to have the following information:

Child's Full Name____

Child's Address:____

Mother's : Work Phone #:___________________________ Cell Phone #: ___________________________

Father's: Work Phone #: ___________________________ Cell Phone #: ___________________________

Home Phone #: ________________________________ Other Emergency Contact #: _______________

Any known allergies or medical condition(s) of child:

____

____

Medical Insurance Information:

Name of Company:____

Name of Member:___________________________________ Policy #:_____________________________

Group Number:_________________________________ Phone Number:____________________________

Signature of Mother:____ Date: ______________________

Signature of Father: ____ Date: _______________________