

CONSENT FOR EMERGENCY MEDICAL TREATMENT-

Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_ . THIS CARE MAY BE GIVEN UNDER

NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____		_____	
DATE		PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE	
_____			
HOME ADDRESS			
_____		_____	
HOME PHONE		WORK PHONE	
(     )		(     )	