

# Emergency Medical Treatment Authorization

Permission for medical care in parental absence.

Child's Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Name child answers to: \_\_\_\_\_

I, \_\_\_\_\_ parent or guardian of the child named above give my permission to \_\_\_\_\_, child care home provider, to secure and authorize such emergency medical care and treatment as my child might require while under the Provider's supervision. I also authorize the Provider 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.

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

Name of Parent or Legal Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Parent or Legal Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Preferred Hospital to Contact: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Persons to be contacted in emergency if the parents are unavailable:

<u>Name</u>	<u>Home Phone</u>	<u>Work Phone</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____

Present medication(s): \_\_\_\_\_

Known allergies: \_\_\_\_\_

Date of last tetanus: \_\_\_\_\_ Religious Preference: \_\_\_\_\_

Insurance: \_\_\_\_\_

Father's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mother's signature: \_\_\_\_\_ Date: \_\_\_\_\_