

# 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:

PLEASE PROVIDE SIBLING INFORMATION BELOW, IF APPLICABLE:

NAME	GRADE	SCHOOL	SCHOOL PHONE
NAME	GRADE	SCHOOL	SCHOOL PHONE
NAME	GRADE	SCHOOL	SCHOOL PHONE

\_\_\_\_\_ DATE

\_\_\_\_\_ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

\_\_\_\_\_ HOME ADDRESS

\_\_\_\_\_ HOME PHONE

\_\_\_\_\_ WORK PHONE