CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO Trinity Presbyterian Preschool
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O.), OR DENTIST (D.D.S.) FOR: ______________________________ .
NAME

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING **MEDICATION** ALLERGIES:

PLEASE INDICATE IF CHILD HAS FOOD ALLERGIES OR ASTHMA. ___ ALLERGY ACTION PLAN HAS BEEN PROVIDED TO TPP

PLEASE PROVIDE SIBLING INFORMATION BELOW, IF APPLICABLE:

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

DATE (M/DD/YY)

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE