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:

CHILD HAS THE FOLLOWING FOOD ALLERGIES. ALLERGY ACTION PLAN HAS BEEN PROVIDED TO TPNS:

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