



EMERGENCY MEDICAL CONSENT

Child's Name _____ Birth Date _____ Gender _____

Address _____ Phone _____

Preferred medical locations in the case of an accident or illness,

Physician's Name _____ Phone _____

Address _____

Dentist's Name _____ Phone _____

Address _____

Hospital Name _____

Address _____

In the event the parent/legal guardian cannot be reached, we will notify the following emergency contacts.

Name _____

Address _____

Phone (Work) _____ Phone (Cell) _____

Name _____

Address _____

Phone (Work) _____ Phone (Cell) _____

Child's personal history of medications, allergies and/or health problems:

Other helpful information regarding your child, such as insurance, etc.:

In the event reasonable attempts to contact us at the above phone numbers have been unsuccessful, we (parents/legal guardians) give consent for the administration of any treatment deemed necessary by the stated physician or dentist and/or activate the emergency response team. Parents/legal guardians will be contacted as soon as practical. The center Director or Teaching Staff will plan to accompany the child to the clinic/preferred hospital until you, the parents/legal guardians, can arrive. *You and your health insurance will be the source responsible for payment of any treatment.

Parent/Legal Guardian Signature _____ Date _____