EMERGENCY MEDICAL TREATMENT AUTHORIZATION

(To be completed by Parent/Guardian)

CHILD/FAMILY INFORMATION

PLEASE PRINT CLEARLY

Child's Name:	Birthdate: / /		Age:

I, _____ parent or guardian of the child named above give my permission to ***Early Blessings Daycare & Learning Center***, to secure and authorize such emergency medical care and treatment as my child might require while under the EBDLC's and it's staff supervision. I also authorize the Staff 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:		
Work Phone:		
Home Phone:		
Cell Phone:		

Name of Parent or Legal Guardian:		
Address:		
Work Phone:		
Home Phone:		
Cell Phone:		

Name of Doctor:
Address:
Office Phone:

Preferred Hospital to Contact:
Address:
Office Phone:

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

Name:	Name:	Name:
Work Phone:	Work Phone:	Work Phone:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Relationship:	Relationship:	Relationship:

Present medication(s): _____ Known allergies: _____

Date of last tetanus: _____ Religious preference: _____

Insurance: _____

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date