

EMERGENCY MEDICAL CONSENT FORM

_____ has my permission to obtain
emergency medical treatment for my child, _____
when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

Mother/Guardian's Name _____

Home Phone _____ Cell Phone _____

E-mail Address: _____

Father/Guardian's Name _____

Home Phone _____ Cell Phone _____

E-mail Address: _____

My insurance provider is _____

My child's medical record number is _____

Preferred hospital/treatment center _____

My child is taking the following medications

My child has the following allergies

☐ I understand that I assume all financial responsibility for any treatment or injuries sustained
by my child while he/she is in child care.

Signature of Parent or Guardian

Date

Signature of Parent or Guardian

Date