EMERGENCY MEDICAL CONSENT

Child's Full Name: _____ Date Of Birth: _____

In the event that my child (listed above) may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent for medical and/or surgical treatment to the _____Hospital and Doctor_____ or his/her designee to provide this care. In the event that my child (listed above) may require dental and/or dental surgical care while I am out of the city or unable to be reached, I hereby give my consent for dental and/or surgical care to _____Hospital and Doctor _____or his/her designee to provide this care. In the event the above doctor, dentist, or hospital are not available or in close proximity when care is needed, I give permission for Children's Center to authorize medical or dental care at the nearest medical facility. I agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

COMMENT: Every effort will be made to notify parents/guardians immediately in case of emergency. This form will be presented upon admission for treatment.

1. Parents/Guardian/Custodians with whom the child resides:

Name_____Address_____Home Phone _____

Work Phone_____ Cell Phone_____Relationship to child: _____

2. Parents/Guardian/Custodians with whom the child resides:

Name_____Address_____Home Phone _____

Work Phone_____ Cell Phone_____ Relationship to child: _____

3. Persons to contact in case of emergency if parents are unavailable (individual is authorized to pick up child):

Name_____ Home Phone _____Cell Phone_____ Relationship to child: _____

4. Persons to contact in case of emergency if parents are unavailable (individual is authorized to pick up child):

Name_____ Home Phone _____Cell Phone_____ Relationship to child: _____

5. Is there any custody or restraining orders for persons who may attempt to pick up or have contact with the child while in care at the center?

Name_____

6. Health Information:

Child's Doctor_____Address:_____ City_____State_____Phone_____

Child's Dentist_____Address:_____ City_____State_____Phone_____

Allergies: _____

Date of Last Tetanus Shot: _____ Present Medications _____

Insurance Company_____Policy Holder's I.D. _____

_____ _____

Signature of Parent/Guardian Date Signature of Parent/Guardian Date