EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Permission for medical care in parental absence.

Child's Full Name _____ Birth Date _____

Name child answers to:_____

I, _____ parent or guardian of the child named above give my permission to _____, child care home provider, to secure and authorize such emergency medical care and treatment as my child might require while under the Provider's supervision. I also authorize the Provider 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:_____
Home Phone:_____ Work Phone:_____

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Address:_____
Home Phone:_____ Work Phone: _____

Doctor:_____
Doctor's Address: _____
Doctor's Phone:_____

Preferred Hospital to Contact: _____
Address:_____Phone:_____

Person(s) to be contacted in emergency if the parents are unavailable:

Name	Home Phone	Work Phone	Relationship

Present medication(s): _____
Known allergies:_____
Date of last tetanus:_____ Religious Preference: _____
Insurance :_____

Father's signature:_____Date:_____

Mother's signature:_____Date: _____