JUMPING JAX KIDS
child care center

Medical Consent Form

Child's Full Name: _____Birthdate: _____

Physician's Name: _____Phone #: _____

Address: _____ City: _____State: _____ Zip Code: _____

Parent's Insurance Company: _____ Contract #: _____

If unavailable, another Licensed Physician may treat my child. Yes _____ No _____

Hospital to be used for Emergencies: _____

Dentist's Name: _____Phone #: _____

Address: _____ City: _____State: _____ Zip Code: _____

Parent's Dental Insurance Company: _____ Contract #: _____

If unavailable, another Licensed Dentist may treat my child. Yes _____ No _____

Mother's Name: _____ Email: _____

Home Phone #: _____ Cell Phone #: _____

Place of Employment: _____Work Phone #: _____

Father's Name: _____ Email: _____

Home Phone #: _____ Cell Phone #: _____

Place of Employment: _____Work Phone #: _____

I give my permission for…

1. My child to receive emergency treatment (First Aid & CPR) by any qualified staff person at Jumping Jax Kids.
2. The center staff to act in the case of emergency, or when a contact cannot be reached or is delayed.
3. My child to be transported by ambulance, aid care or owner's vehicle to an emergency center for treatment.
4. The medical, surgical, and hospital care treatment and procedure to be performed for my child by a licensed physician or hospital when deemed immediately necessary to safeguard my child's health.

In the event of an emergency, I agree to pay all costs of transportation and all medical related costs.

Signature _____ Date: _____

Signature _____ Date: _____