

**CONSENT FOR EMERGENCY MEDICAL TREATMENT-  
Child Care Centers Or Family Child Care Homes**

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME  
 PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER WHATEVER  
NAME  
 CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED  
 ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_  
DATE\_\_\_\_\_  
PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE\_\_\_\_\_  
HOME ADDRESS\_\_\_\_\_  
HOME PHONE

( )

\_\_\_\_\_  
WORK PHONE

( )