I (We) _____
Name(s)

Of _____do hereby state
City County State

That I am (we are) the parents/guardians, having legal custody of _____
Child's Name

A minor, age ___, born _____ who resides with me (us) at _____
Address

I (We) authorize Jefferson Child Care and Education Center, P.O. Box 527: 29 Nolan's Point Rd., Lake Hopatcong, NJ 07849, to consent to an X-Ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general supervision of a licensed Physician or Surgeon.

Dated this _____day of _____, _____.

_____
Signature of Parent (s) or Guardian (s)

Witness _____Date _____

Existing medical problems of child, in any _____

Existing allergies, if any _____

Child's Doctor _____Doctor's phone #_____

Specialist _____Parent's Doctor _____

Medications that child is taking _____

Insurance Company _____Group _____
** Please attach a copy of your child's medical insurance card **

Identification # _____Last tetanus shot_____

Provided as a Public Service by
Northwest Covenant Medical Center
Sponsored by the Sisters of Sorrowful Mother

Department of Emergency Medicine:
Dover General Campus, Dover …. 973-989-3200
St. Clare's, Denville …….. 973-625-6063