Chiemsee Castle Daycare/ Preschool LLC
Medical Treatment Consent for Minors

Childs Name:_____ Birth Date:_____
Address:_____
Father's Name: _____Employer: _____
Home Phone: _____ Work phone: _____
Mother's Name: _____ Employer: _____
Home Phone: _____ Work phone: _____
Child's Doctor: _____
Family Doctor: _____
Child is Allergic
To: _____
Medical Information (Include last Tetanus shot if know, or major illnesses

Insurance Company name: _____
Policy/ group Number: _____
Responsible / Insurance Card
Holder:_____
Hospital Choice (if necessary): _____
Dear parent or Guardian:

This card should be presented to the attending physician if your child is in need medical treatment during your absence.

You can have each child (through 18 years) carry a card with him or her or have it available when you are absent. This card will prevent delay of treatment for your child because of lack of proper authorization.

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child:

In the event of medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and both physicians and nursing personnel within the hospital as well as any physician where treatment is required in the physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians from performing medical procedures acting on authority of this medical treatment from which are deemed necessary for my minor child.

_____
Signature of Parent or Legal Guardian