EMERGENCY MEDICAL CONSENT

Parent/Guardian: _____
Address: _____
Telephone: (___) _____

Name and address of relative, friend or otherwise responsible person to contact in case parents cannot be reached:
Name: _____
Address: _____
Telephone: (___) _____

EMERGENCY MEDICAL AUTHORIZATION

I authorize _____ to obtain immediate consent and care to
(Family Day Care Provider's Name)
emergency medical procedures upon, the hospitalization of, the performance of necessary diagnosis tests upon, the use of surgery on, and/or the administration of drugs to _____if an emergency occurs and I cannot be located immediately.
(Child's Name)

I further understand that this agreement covers only those situations which are true emergencies and only when I cannot be reached.

Physician / Clinic: _____

Address: _____

Hospital: _____

_____ _____
PARENT'S SIGNATURE **DATE**

Name of Insurance Company / Medicaid: _____
Address: _____ Telephone: (___) _____
Policy / Medicaid Number: _____