PARENTAL EMERGENCY MEDICAL CONSENT

Child's Full Name_____ Date of Birth_____

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached. **This form must be presented upon admission for treatment.** In the event reasonable attempts to contact me at_____(phone number) or_____(phone number) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor_____ (physician) at_____ (phone number) or Doctor_____(dentist) at _____(phone number) or in the event the designated practitioners are not available, then by another licensed physician or dentist; and the transfer of the child to _____(preferred hospital).

1. Parents/Guardians with Whom the Child Resides:

***Name**_____ Relationship to Child_____

Address_____ Home Phone_____

Employer_____ Cell Phone_____

***Name**_____ Relationship to Child_____

Address_____ Home Phone_____

Employer_____ Cell Phone_____

Work Phone_____ Email Address_____

2. Persons Authorized to Pick Up Child (Please list additional persons on the back of this form.)

***Name**_____ Relationship to Child_____

Address_____ Home Phone_____

Employer_____ Cell Phone_____

Work Phone_____ Email Address_____

***Name**_____ Relationship to Child_____

Address_____ Home Phone_____

Employer_____ Cell Phone_____

Work Phone_____ Email Address_____

3. *Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the preschool?*

_____

_____ If your child will be riding the bus after school (4s only), please initial on this line giving permission for us to place your child on the bus to go home. Once the child is on the bus; they are the responsibility of Central DeWitt Community School District.

_____ _____

Signature Parent/Guardian Date Signature Parent/Guardian Date