

**AUTHORIZATION FOR EMERGENCY TREATMENT**

Permission for the Director, Acting Director, or the teacher to take whatever steps may be necessary for medical care of an emergency is hereby given. I understand that the order of actions taken will follow the outline below unless there is a need for immediate action, but will not be limited to these actions.

1. Parent or guardian will be called
2. Child's physician will be called
3. Contact person will be called (that parents have listed)
4. If none of these efforts are successful:
  - a. Another physician will be called
  - b. An ambulance will be called
  - c. The child will be taken to the emergency room of Nicklaus Children Hospital accompanied by a staff member.
5. In order for the school to assume responsibility for my child, I understand that I must sign the child in and out at departure time.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent / Guardian

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Witness

**RELEASE FOR EMERGENCY CARE**

TO WHOM IT MAY CONCERN:

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child, \_\_\_\_\_ in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if situation warrants it.

\_\_\_\_\_  
Family Physician's Name Phone #

Allergies: \_\_\_\_\_

Insurance company covering child: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

State of \_\_\_\_\_ County of \_\_\_\_\_  
On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me came \_\_\_\_\_, to me known to be the individual described in and who executed the foregoing instrument and acknowledged that he executed the same. Type of identification \_\_\_\_\_

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Print Name

The form must contain only one child's name, must not be a copy, and must be updated annually.

**FIRST AID AND EMERGENCY MEDICAL CARE  
CONSENT FORM**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to Nickalos Children Hospital, and to secure necessary medical treatment for my child.

Child's Physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_  
Chronic Health Conditions: \_\_\_\_\_

**Emergency Contacts (In order to be contacted)**

1. Name:	Address:
Relationship to Child:	Phone #:
Do you give permission for child to be released to this person?	Yes No
2. Name:	Address:
Relationship to Child:	Phone #:
Do you give permission for child to be released to this person?	Yes No
3. Name:	Address:
Relationship to Child:	Phone #:
Do you give permission for child to be released to this person?	Yes No

Health Insurance Coverage:	Policy #:
Parent(s) Name:	Phone(w) Phone (h)
Parent(s) Name:	Phone(w) Phone (h)

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**