

# Time to Shine Preschool, LLC Parental Consent to Treat Form

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Emergency Phone #'s: \_\_\_\_\_

**(Please list medical problems, allergies and other pertinent information on the back of this form)**

To Whom it May Concern:

The undersigned does hereby give permission for the above-named child to attend and participate in activities sponsored by Time to Shine Preschool, LLC. I understand that in the event medical treatment is required for the above-named child, every effort will be made to contact me. However, if I cannot be reached, I authorize an adult in whose care the minor has been entrusted to consent to any x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care to be rendered to the minor under the general supervision and on the advice of any licensed physician or dentist or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services and emergency medical transportation, rendered to the aforementioned child pursuant to this authorization.

Parent/Guardian Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name Printed: \_\_\_\_\_

Parent/Guardian Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name Printed: \_\_\_\_\_

## Illness Policy

I understand and agree with Time to Shine Preschool, LLC's illness policy. I also agree to report any contagious illnesses i.e. pink eye, hand, foot and mouth, strep throat, lice, COVID-19 etc. that my child may have exposed other children to. **Initial** \_\_\_\_\_