

---

---

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

---

---

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER  
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD  
NAMED ABOVE.

---

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_

DATE

\_\_\_\_\_

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

\_\_\_\_\_

HOME ADDRESS

\_\_\_\_\_

HOME PHONE

( )

\_\_\_\_\_

WORK PHONE

( )