# 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:

**One out-of-state (or if no out of state relative, out of town) contact phone number and email address is to be used as an intermediary for communications in the event that parents/guardians cannot be reached directly.**

**Name:**_____ **Relationship:**_____

**Contact Phone Number:**_____

**Email address:**_____

**Signature** **Date**

**Home Address**

**Home Phone** **Work Phone**

**Email Address**