CHILD'S FULL NAME____

MEDICAL RELEASE

In the event that my child becomes ill or sustains an injury while in the care of the Children's Center, I give my permission to those in charge to take whatever steps are necessary to give urgent first aid care.

If it is not possible to reach me or the physician named below consent is given to any licensed physician and/or surgeon to treat, administer drugs or medicines and to perform such surgical procedures as the physician shall think the existing emergency requires for the relief of pain and to preserve my child's life and health.

I give my permission for my child to be transported by ambulance or in a staff member's private car if necessary.

I have listed below all known allergies or reactions my child has to any drugs or medication.

EMERGENCY MEDICAL RELEASE FORM

Child's full name____

Home address ______________________Telephone______________________

Telephone where authorizing parent can be reached____________________

Child's Physician _______________________Telephone________________

Office address____

Hospital preferred____

Known allergies____

____

____

Parent or Guardian Signature   Date