LINCOLN BASP

Emergency Medical Treatment Authorization/Consent Form

Child's Full Name: _____

Birth Date:_____ Child's Age: _____ Child's Gender: _____

I, _____ parent or guardian of the child named above, give my permission to Lincoln Elementary Before and After School Program (LBASP), to secure and authorize such emergency medical care, emergency dental care and treatment as my child might require while under the LBASP's supervision. I also authorize LBASP to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

Note: Every effort will be made to notify parents immediately in case of emergency. Please provide the following information to help us facilitate the care of your child should the need arise.

Please fill out completely

Name of Parent or Legal Guardian: _____
Address: _____
Home Phone: _____ Cell Phone: _____

Name of Parent or Legal Guardian: _____
Address: _____
Home Phone: _____ Cell Phone: _____

Physician: _____
Address: _____
Phone: _____

Dentist: _____
Address: _____
Phone: _____

Medications (Please list all medications presently taking): _____

_____

Child's last physical examination: _____

Known allergies: _____

If your child's religious affiliation is contrary to medical treatment of immunization requirements, you have provided the center a notarized statement on (date):_____