

**EMERGENCY MEDICAL CONSENT FORM**

\_\_\_\_\_ has my permission to obtain  
emergency medical treatment for my child, \_\_\_\_\_  
when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

**Mother/Guardian's Name** \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Father/Guardian's Name** \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address: \_\_\_\_\_

My insurance provider is \_\_\_\_\_

My child's medical record number is \_\_\_\_\_

Preferred hospital/treatment center \_\_\_\_\_

My child is taking the following medications

\_\_\_\_\_

My child has the following allergies

\_\_\_\_\_

I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in child care.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date