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

NAME

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

FACILITY NAME TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

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

_____ . THIS CARE MAY BE GIVEN UNDER

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

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

HOME ADDRESS	
HOME PHONE	WORK PHONE
()	()