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

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

PLAY DATE Preschool & School Age
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

_____ BORN: ___ ___ ___
CHILD'S FIRST AND LAST NAME — MO DAY YEAR

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:

WHAT IS THE EXPECTED REACTION TO THE ABOVE MENTIONED MEDICATION ALLERGIES:

AND / OR FOOD ALLERGIES:

WHAT IS THE EXPECTED REACTION TO THE ABOVE MENTIONED FOOD ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

CELL PHONE:	WORK PHONE:	HOME PHONE:
AREA CODE	AREA CODE	AREA CODE