

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

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

[REDACTED] TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

FACILITY NAME

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

[REDACTED] . THIS CARE MAY BE GIVEN UNDER

NAME

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

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

[REDACTED] DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE

[REDACTED] ( [REDACTED] )

WORK PHONE

[REDACTED] ( [REDACTED] )

