Child Care Provider Medical Consent Form

Valid from _____ to _____

Child Information

Child's Name:_____ Child's Date of Birth:_____

Child's Doctor:_____ Doctor's Phone Number:_____

Preferred Hospital: _____

Child's Allergies and Medical Conditions: _____

Child's Past Surgeries:_____

Child's Medications:_____

Child's Health Insurance Provider:_____ Policy Number:_____

Parent/Guardian Information

Custodial Parent/Guardian Name(s):_____ Phone Number:_____

Address:_____

Custodial Parent/Guardian Name(s):_____ Phone Number:_____

Address:_____

Caregiver Information

In the case that no parent/guardian can be reached, please allow the following named individual to make medical decisions for the above named child/children:

Caregiver's Full Legal Name:_____ Date of Birth:_____

Address:_____ Phone Number:_____

Relationship to Child:_____