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 Name	
Cell phone	Home Phone:
Email Address	

Father Name	
Cell phone	Home Phone:
Email 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