PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name Of Child: | | | | | Birthdate: | | | Enrollment Date: | |
|  | | | | | | | | | |
| PARENT/GUARDIAN INFORMATION |  | PARENT/GUARDIAN # 1 | |  |  |  | PARENT/GUARDIAN # 2 | | |
| Name: |  | | | Name: |  | | | |
| Relationship: |  | | | Relationship: |  | | | |
| Cell Phone: |  | | | Cell Phone: |  | | | |
| Home Phone: |  | | | Home Phone: |  | | | |
| Home Address: |  | | | Home Address : |  | | | |
| Employer Name: |  | | | Employer Name: |  | | | |
| Employer Phone: |  | | | Employer Phone: |  | | | |
| E-Mail Address: |  | | | E-Mail Address: |  | | | |
|  | | | | | | | | | |
| EMERGENCY CONTACTS | Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child. | | | | | | | | |
| Contact Name #1: |  | | Contact Name #2: |  | | Contact Name #3: | |  |
| Relationship: |  | | Relationship: |  | | Relationship: | |  |
| Cell Phone: |  | | Cell Phone: |  | | Cell Phone: | |  |
| Home Phone: |  | | Home Phone: |  | | Home Phone: | |  |
| Employer Phone: |  | | Employer Phone: |  | | Employer Phone: | |  |
|  | | | | | | | | | |
| CUSTODY | Name of person PROHIBITED from picking up your child: | | | |  | | | | |
| If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order. | | | | | | | | |
|  | | | | | | | | | |
| MEDICAL INFORMATION | Child’s Health Care Provider: | |  | | | | | | |
| Health Care Provider Phone: | |  | | | | | | |
| Health Care Provider Address: | |  | | | | | | |
| Name Of Insurance Company/Hmo: | |  | | | | | | |
| Group #: | |  | | | | | | |
| Identification #: | |  | | | | | | |
| Subscriber’s Name On Insurance Card: | |  | | | | | | |
| Known Allergies (including medication): | |  | | | | | | |
| Medication My Child Is Taking: | |  | | | | | | |
| List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations: | |  | | | | | | |
|  | | | | | | | | | |
| AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT | | | | | | | | | |
| As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified. | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian Signature #1: | Date: | Parent/Guardian Signature #2: | Date: |

OOL/11.6.2017

Page **1** of **2**