



## Parental Authorization For Emergency Treatment

Name of Child: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

### Parent Guardian Info #1

### Parent Guardian Info #2

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_  
 Employer Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**EMERGENCY CONTACTS:** Please list 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#1

### Contact#2

### Contact#3

Relationship: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Employer Phone: \_\_\_\_\_

**CUSTODY:** 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.

Name of person PROHIBITED from picking up your child: \_\_\_\_\_)

**MEDICAL INFORMATION:** Please fill out medical information fields below.

Child's Health Care Provider: \_\_\_\_\_ Health Care Provider Phone: \_\_\_\_\_

Health Care Provider Address: \_\_\_\_\_ Name of Insurance Company/HMO: \_\_\_\_\_

Group #: \_\_\_\_\_ Identification #: \_\_\_\_\_ Subscribers Name: \_\_\_\_\_

Known Allergies (including Medications): \_\_\_\_\_

Medications my Child is Taking: \_\_\_\_\_

Special conditions, disabilities, medical/physical restrictions, medical info, 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 childcare center staff to obtain emergency treatment for my child and I understand that I (we) shall be promptly notified:

Parent/Guardian Signature #1: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature #2: \_\_\_\_\_ Date: \_\_\_\_\_