

PARENTAL PERMISSION FOR EMERGENCY MEDICAL TREATMENT

I understand that it is my responsibility to see that my child (name) _____, has regular medical examinations as required for attendance at the centre and that my child’s immunizations are kept up to date as required by The Department of Children and Families according to his/her age.

Should my child, listed above, become ill or suffer an accident of any kind while in the care of the centre, the centre shall contact the parent or guardian immediately. In the event the centre is unable to reach the parent or guardian, it shall be authorized to secure such medical attention and care for the child as may be necessary. I understand that I am responsible for any fees not covered by the centre’s insurance.

Signature _____
(Parent or Guardian) (Date)

On this date the above named person appeared before me and verified that he/she understands and agrees to the above stated PARENTAL PERMISSION FOR EMERGENCY MEDICAL TREATMENT.

_____ My commission expires: _____
(Notary Public)

MEDICAL INFORMATION

My child is covered with the following medical insurance:

Insurance Company _____ Group number _____

Medicaid number _____

List all of your child’s allergies:

List child’s regular medications prescribed by your doctor:

Medication: _____

Reason: _____

Is child on a special diet? Yes No If yes please describe diet:

Signature _____ Date _____