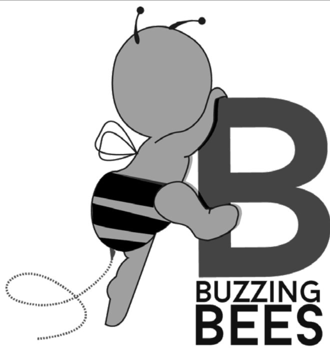

EMERGENCY MEDICAL TREATMENT & TRANSPORTATION FORM APPLICATION

PERSONAL INFORMATION

Name Of Child:		Date Of Birth:					
Gender	○ Male ○ Female	HOME PHONE#:					
Mailing Address:		CITY:		STATE:		ZIP CODE:	

MEDICAL DETAILS

Medical Issues:		Allergies:	
Medical Insurance Plan:		Phone Number:	
Policy Number:		Policy in Name of:	
Physician's Name:		Office Number:	
Dentist Name:		Office Number:	

PARENT/GUARDIAN # 1		PARENT/GUARDIAN # 2	
Name:		Name:	
Place of Employment:		Place of Employment:	
Work Phone:		Work Phone:	
Cell Phone:		Cell Phone:	

EMERGENCY CONTACT (OTHER THAN PARENTS & PHYSICIAN)

Name:		Relationship:	
Work Phone:		Cell Phone:	

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above childcare center director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in an emergency:

1. The parent/guardian will be contacted immediately.
2. The child's health care provider will be contacted.
3. We will attempt to contact the parent through all of the emergency contacts listed above.
4. If we cannot contact the parent/guardian or your child's health care provider, we will do any or all of the following:

A. Call for Emergency First Aid assistance/ transportation.

B. Call another health care provider.

C. Have the child transported to an emergency hospital in the company of a staff member.

Parent's/Guardian's Signature: ______________________ Date: ______________

Witness: ______________________ Date: ______________