Children's Choice Early Learning Center

115 S 3rd Avenue

Eldridge, IA 52748

Parental Emergency Medical Consent

This form must be present upon admission for treatment

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration Of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

Child's Name:		
Parent(s) Guardians with whom the Child Resides:		
1. Name	**Relationship to Child**	
Address	**Employer**	
Home #	**Cell #**	**Work #**
2. Name	**Relationship to Child**	
Address	**Employer**	
Home #	**Cell #**	**Work #**
Emergency Contact Person(s)		
1. Name	**Relationship to Child**	
Home #	**Cell #**	**Work #**
2. Name	**Relationship to Child**	
Home #	**Cell #**	
3. Name	**Relationship to Child**	
Home #	**Cell #**	**Work #**

Persons Authorized To Pick Up Child	Address	Phone Number
1.		
2.		
3.		

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

Name	**Name**

Physician Name	**Dentist Name**
Phone #	**Phone #**
Address	**Address**
Hospital Preference	
Known Allergies	**Date of Last Tetanus**
Present Medication	
Insurance Company	**Policy Holder ID**

This consent will be in effect for one year beginning (date) _____

_____

Signature of Parent or Guardian **Date**

_____

Signature of Parent or Guardian **Date**