EMERGENCY MEDICAL CONSENT

DATE:_____

I,_____**, hereby give my consent for EMERGENCY MEDICAL CARE to be provided for my Child,**_____ **while (he or she) is in the care of NEW CARROLLTON EARLY LEARNING CENTER.**

Child's Physician_____

Physician's Address_____

Physician's Phone Number_____

Insurance Company_____

Policy Number_____

In case of an EMERGENCY, I can be reached at :

Home Phone Number:_____

Work Phone Number:_____

Cell Phone Number:_____

Other Emergency Contact:_____

_____

Please answer the following questions:

1. My child is allergic to the following:_____

_____

2. My child takes the following medication on a daily basis:_____

_____

3. My child has the following health condition which may require emergency action while at the center(Please Specify, e.g. seizures, diabetes, etc):_____

_____

List all pertinent information that might be helpful to an Emergency Room Physician:_____

_____

SIGNATURES(PARENT/GUARDIAN)_____

_____

Address:_____