EMERGENCY MEDICAL TREATMENT AUTHORIZATION

CHILD'S NAME (LAST, FIRST):_____ **DATE:** _____

MEDICAL INFORMATION

Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:

_____

Child's Usual Physician: _____Phone: _____

Physician's Address: _____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of Meeting House Montessori School to provide simple first aid treatment to my child, _____when necessary. In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that I will be contacted by child care program personnel as soon as possible regarding any emergency involving my child.

Parent/Guardian Name (please print):_____

Parent/Guardian Signature:_____ **Date:**_____