

Brandi "B" Day Care

Medical Emergency Treatment Consent Form

I _____ (name of parent), give permission for Brandi "B" Day Care to provide all necessary emergency medical, dental or other care for _____ (name of child). This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependant.

I further authorize that emergency care/treatment (First Aid and CPR) be given to my child by a qualified caregiver at Brandi "B" Day Care as needed, until medical assistance is available.

I also give my permission for my child to be transported by ambulance and treated by EMT staff as needed to an Emergency Center in the case of an emergency that can not be handled at Brandi "B" Day Care and deemed necessary by the staff.

In the event that I cannot be contacted, I further consent to the medical, surgical, and hospital care treatment and procedures to be performed for my child by a licensed Physician or Hospital when deemed immediately necessary or advisable by the Physicial to safeguard my child's health.

In the case of the emergency and if emergency transportation is needed, I agree to pay all costs and fees contingent of any emergency medical care and/or treatment for my child as secured or authorized under this consent.

Child's Name _____
Social Security # _____

(A photocopy of my child's insurance information is attached.)

The provider is required to try to contact me, the other parent or legal guardian at one of the below telephone numbers. At no time will the provider attempt to drive the sick or injured child to an emergency medical facility.

Parent or Legal Guardian's Name _____

Telephone Numbers _____ (day)

Telephone Numbers _____ (evening)

Telephone Numbers _____ (other)

Parent or Legal Guardian's Name _____

Telephone Numbers _____ (day)

Telephone Numbers _____ (evening)

Telephone Numbers _____ (other)

Emergency contact (Friend or relative NOT living in the home)

Name _____

How do you know this person: _____

Telephone Numbers _____ (day)

Telephone Numbers _____ (evening)

Telephone Numbers _____ (other)

Medical Insurance Information

Name of Company

Name of Member

Policy Number

Group Number

Phone Number

Date of Last Tetanus: _____

Physician/ Emergency Care Hospital you prefer:

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SPECIFIC INSTRUCTIONS OF PARENT/ GUARDIAN (i.e. Allergies, ongoing medication, restrictions for treatment, etc.):

(Signature of Parent or Legal Guardian)

Date