



# Emergency Medical Treatment Authorization/Consent Form

**Please fill out this form completely or it will be returned to you to finish.**

This form was completed on \_\_\_\_\_

Child's Full Name _____
Birth Date _____
Child's Age _____
Child's Sex _____

I, \_\_\_\_\_ parent or guardian of the child named above give my permission to Helping Hands Preschool & Child Care Inc., to secure and authorize such medical care, emergency dental care and treatment as my child might require while under the Center's supervision. I also authorize the Center to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

**NOTE: Every effort will be made to notify parents immediately in case of an emergency. In the event of an emergency, it would be necessary to have the following information:**

Name of Parent or Legal Guardian: _____	
Address: _____	
Phone Numbers: _____	Place of Employment: _____
Cell #: _____	Employer #: _____
Name of Parent or Legal Guardian: _____	
Address: _____	
Phone Numbers: _____	Place of Employment: _____
Cell #: _____	Employer #: _____

**IF YOUR CHILD DOES NOT HAVE A DOCTOR OR DENTIST, YOU WILL BE REFERRED TO Siouxland Community Health Center**

Doctor: _____
Doctor's Address: _____
Doctor's Phone: _____
Preferred Hospital to Contact: _____
Dentist: _____
Dentist's Address: _____
Dentist's Phone: _____

Present medication(s): _____
Known allergies (Doctor must fill out & sign a care plan): _____
Insurance: _____
Any special needs? _____

**The following individuals may be contacted in case of an emergency and my child may be released to them:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: \_\_\_\_\_ Home: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work/School: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: \_\_\_\_\_ Home: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work/School: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: \_\_\_\_\_ Home: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work/School: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Numbers: \_\_\_\_\_ Home: \_\_\_\_\_  
Cell: \_\_\_\_\_ Work/School: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_

By signing below, I give consent for:

My child to attend center-sponsored field trips. This may include walking, car, van, bus or public transportation.

Center staff to transport my child to and from school in a center-owned vehicle using only one staff. My child attends \_\_\_\_\_ Elementary school.

Sun block to be applied to my child's skin.

My child's picture to be taken and/or videotaped for use by Helping Hands.

\*Surveillance cameras are located throughout Helping Hands and are recording audio and video at all times.

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_