10:122-6.8 Parent and community participation
May be completed by parent to authorize emergency treatment

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

CHILD'S NAME ____
Age ________________________ Date of Birth ____________________
Address ____
PARENT (S) NAME ______________________________________
Parent(s) Address ____

CHILD'S MEDICAL INFORMATION
Medical Problems ____
Allergies
Medicine(s) Child is Taking ___________________________________
Medicine(s) Child is Allergic To _________________________________
Name of Child's Doctor ________________ Telephone __________________

CHILD'S INSURANCE
Company/HMO ____
Group Number ______________________ ID # _______________________

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above childcare center director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

<u>The following steps will be followed in an emergency:</u>

1. The parent/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact you through all of the emergency person's listed on the child's application form.
4. If we cannot contact you of your child's physician, we will do any of all of the following:
   (a) Call for emergency first aid assistance/transportation.
   (b) Call another physician.
   (c) Have the child transported to an emergency hospital in the company of a staff member.

Parent Signature: ____
Date of Signature: _________________ Date permission terminated: ____________
Witness: __________________________ Date: _______________________