

CONSENT FOR MEDICAL TREATMENT FOR A MINOR CHILD

Child's Name _____ Birthdate _____

Home Address _____
Street City Zip

EMERGENCY CONTACT INFORMATION

Parent or Guardian 1 _____

Home Phone _____ Work Phone _____ Cell Phone _____

Parent or Guardian 2 _____

Home Phone _____ Work Phone _____ Cell Phone _____

In the case of emergency, we will attempt to contact both parents/guardians listed above. If these two people are unavailable, who else can make medical decisions for your child?

Emergency Contact 1 Name _____ **Relationship** _____

Phone 1 _____ Phone 2 _____

Emergency Contact 2 Name _____ **Relationship** _____

Phone 1 _____ Phone 2 _____

MEDICAL HISTORY

Child's Physician Physician phone	Child's Dentist Dentist Phone	Other significant medical information
Allergies	Medications	Date of last DPT

I give permission to Happy Days Preschool to make whatever emergency measures are judged necessary for the care and protection of my child while under the supervision of the School. In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by a local emergency resource. My child will be transported at my own expense.

Signature of parent/guardian _____ Date _____

I understand that in some medical situations, the staff may need to contact a local emergency resource before the parent, the child's physician and/or other adult acting on the parent's behalf.

Signature of parent/guardian _____ Date _____

I give permission to Happy Days Preschool to contact Poison Control Center or emergency room for advice before and concerning the use of IPECAC syrup, which is used to cause vomiting in case of poisoning.

Signature of parent/guardian _____ Date _____

I give my permission to Happy Days Preschool to take my child on supervised walking excursions and field trips.

Signature of parent/guardian _____ Date _____