

Permission for Emergency Medical Treatment

Name of Child _____ Age _____ Sex: **M** **F** Birth date _____

Address _____ Home phone _____

Parents names _____

Address of Parents: _____

Emergency Phone _____ Father's work # _____ Place of employment _____

Mother's work # _____ Place of employment _____

Other phones (cellular, pager, etc.) _____

When neither parent can be located by phone, contact:

Name _____ **Relationship** _____ **Phone** _____

Address _____

Name _____ **Relationship** _____ **Phone** _____

Address _____

Physician's name _____ **Phone** _____ **Recent exam date:** _____

Address of Physician: _____

Hospital Preferred _____

Insurance Company _____ **Policy #** _____

Describe any allergies (food, medication, etc.), chronic illnesses, current medications, or other medical information that would be helpful in a medical emergency.

In the event that an emergency concerning my child should arise while he/she is participating in the First Presbyterian Church Preschool Ministry and I am unable to be contacted, I hereby give permission to the physician(s) selected by the staff of the program to administer any medications or treatments, including emergency surgery that are deemed necessary.

Parent or guardian signature _____

Notary _____

Taken, subscribed and sworn to before me this _____ day of _____, 20_____

My commission expires _____

As per hospital policy, this medical form must be notarized before we can accept it.