Longwood Medical Area Child Care Center

GROUP CHILD CARE AND SCHOOL AGE CHILD CARE
FIRST AID AND EMERGENCY MEDICAL CARE
CONSENT FORM
102 CMR 7.09(3)

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to_____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)

1. Name:	Address:	
Relationship to Child:	Phone #:	
Do you give permission for child to be released to this person?	Yes ☐	No ☐
2. Name:	Address:	
Relationship to Child:	Phone #:	
Do you give permission for child to be released to this person?	Yes ☐	No ☐
3. Name:	Address:	
Relationship to Child:	Phone #:	
Do you give permission for child to be released to this person?	Yes ☐	No ☐

Health Insurance Coverage:		Policy #:
Parent(s) Name:	Phone(w)	Phone (h)
Parent(s) Name:	Phone(w)	Phone (h)

_____ _____

Parent/Guardian Signature **Date**

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