CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO	
TC	O OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR	
NAME	. THIS CARE MAY BE GIVEN UNDER
WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD	
NAMED ABOVE.	
CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:	
DATE	PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE
HOME ADDRESS	
HOME PHONE	WORK PHONE
()	()

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