

EMERGENCY CONSENT CARD

		Name of Facility _____	
Child's Name:	_____	Birthdate:	_____
	Surname First Name (s)		Year / Month / Day
Address:	_____		

1. Parent's Name:	_____	Child lives with:	_____
Work Phone:	_____	Home Phone:	_____
2. Parent's Name:	_____		
Work Phone:	_____	Home Phone:	_____
Emergency Contact:	_____	Phone:	_____
Child's Doctor:	_____	P hone:	_____
1. Allergies	_____		
2. Medications	_____		
Care Card #:	_____		

CONSENT FORM

It is the policy of this Centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

1. I give consent for my child to be taken to the nearest emergency medical center when I cannot be contacted.
2. I give consent for my child to receive medical treatment.

Pic

Signature of Parent/Guardian

Witness

Date

Personal information contained on this form is collected under the Community Care and Assisted Living Act and will be used only for the purpose indicated.

Eye Colour _____

Hair Colour _____

Any distinguish mark of identification _____