

Medical Alert Information (i.e., allergies, medical and/or handicapping conditions): _____

List any additional information which would be beneficial for the child care staff to know about your child: _____

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Hospital: _____

NOTE: Immunization Record should accompany child.

EMERGENCY CONTACT (OTHER THAN PARENTS):

1. _____
NAME RELATIONSHIP PHONE

2. _____
NAME RELATIONSHIP PHONE

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If my child, _____, should become ill or
CHILD'S FULL NAME

Injured at, _____, I understand that the
NAME OF FACILITY

Facility will: (1) Contact me immediately and (2) Contact the person (s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

SIGNATURE RELATIONSHIP DATE

(OPTIONAL)

Sworn to and subscribed before me this _____, day of _____, 20_____.

Notary Public, State of Florida – At Large.

My Commission Expires: _____

_____ who is/are personally known to me

_____ who has/have produced identification: _____