Child Care Treatment Authorization

Child's Name _____ Date of Birth _____

Parent(s) / Guardian Name _____ Social Security # _____

Parent Address _____ Phone # (Home) _____

City / State / Zip _____

Caregiver's Name _____ Phone # _____
(The Adult Given Supervisory Responsibility Over A Child By A Parent or Guardian)

Emergency Contact _____ Phone # _____
(Other Then Caregiver)

I hereby grant the following individual(s) _____ *the power to authorize consent for all emergency, medical and/or surgical treatment for my child which may be required in my/our absence. If possible, I/we would like to have my/our doctor consulted in connection with such treatment. Also, attempt to contact me/us at the following telephone number.*

_____

The authority granted hereby shall be extended only for the time period(s) of: _____, 19____

Significant Medical History:

_____

_____

_____

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_____

_____

_____

Allergies:

Medications

_____

_____

_____

_____

_____

Other

_____

_____

_____

Current Daily Medications:

_____

_____

_____

_____

Immunizations Up-to-Date

☐ Yes ☐ No

Tetanus/Date: _____

Insurance Information:

Primary Company Name

_____

Policy # _____

Guarantor's Name: _____

Child's Physician Information — For Office Use Only

_____ _____

Signature of Parent / Guardian Date