

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Name Of Child:	Birthdate:	Enrollment Date:
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PARENT/GUARDIAN INFORMATION	<input type="checkbox"/> PARENT/GUARDIAN # 1	<input type="checkbox"/> PARENT/GUARDIAN # 2
	Name:	Name:
	Relationship:	Relationship:
	Cell Phone:	Cell Phone:
	Home Phone:	Home Phone:
	Home Address:	Home Address :
	Employer Name:	Employer Name:
	Employer Phone:	Employer Phone:
E-Mail Address:	E-Mail Address:	

EMERGENCY CONTACTS	Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.					
	Contact Name #1:	Contact Name #2:	Contact Name #3:			
	Relationship:	Relationship:	Relationship:			
	Cell Phone:	Cell Phone:	Cell Phone:			
	Home Phone:	Home Phone:	Home Phone:			
Employer Phone:	Employer Phone:	Employer Phone:				

CUSTODY	Name of person PROHIBITED from picking up your child:
	If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order.

MEDICAL INFORMATION	Child's Health Care Provider:
	Health Care Provider Phone:
	Health Care Provider Address:
	Name Of Insurance Company/Hmo:
	Group #:
	Identification #:
	Subscriber's Name On Insurance Card:
	Known Allergies (including medication):
	Medication My Child Is Taking:
	List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations:

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Signature #1:	Date:	Parent/Guardian Signature #2:	Date:
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