T-TH Preschool ______
MWF Preschool ______
M-F Preschool ______
Daycare ______ Hours: _______ to _________

HOLY FAMILY TEDDY BEAR CLUB

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment

Registration ______
Materials ______
Tuition ______

Child's Full Name: ____ **Date of Birth** _______________________

Name you want child **called** and **printed** on papers _____________________________________**SSN**: __________________

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached. In the event reasonable attempts to contact me at _____________ (phone #) or ____________ (phone #) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Doctor ___________________ (physician) at________________ (phone #) or Doctor ___________________ (dentist) at ___________________ (phone #) or in the event the designated practitioners are not available, then by another licensed physician or dentist; and transfer the child to ___________________________ (preferred hospital).

1. Parents/Guardians/Custodians with Whom the Child Resides:

Name_____________________________________ Full Address (City/St/Zip) ____
Relationship to Child ________________________________ Home Phone _________________________ Cell Phone _____________________________
Employer _____________________________________ Work Hours _________________ Department ______________ Work Phone_____________

OR

Name_____________________________________ Full Address (City/St/Zip) ____
Relationship to Child ________________________________ Home Phone _________________________ Cell Phone _____________________________
Employer _____________________________________ Work Hours _________________ Department ______________ Work Phone_____________

2. Person to Contact in an Emergency if parent can not be reached:

Name_____________________________________ Full Address (City/St/Zip) ____
Relationship to Child ________________________________ Home Phone _________________________ Cell Phone _____________________________
Employer _____________________________________ Work Hours _________________ Department ______________ Work Phone_____________

OR

Name_____________________________________ Full Address (City/St/Zip) ____
Relationship to Child ________________________________ Home Phone _________________________ Cell Phone _____________________________
Employer _____________________________________ Work Hours _________________ Department ______________ Work Phone_____________

3. Persons authorized to pick up Child from school in addition to parents:

Name______________________________________ Full Address (City/St/Zip)____
Relationship to Child ________________________________ Home Phone _________________________ Cell Phone _____________________________
Employer _____________________________________ Work Hours _________________ Department ______________ Work Phone_____________

OR

Name______________________________________ Full Address (City/St/Zip) ____
Relationship to Child ________________________________ Home Phone _________________________ Cell Phone _____________________________
Employer _____________________________________ Work Hours _________________ Department ______________ Work Phone_____________

4. Any restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

Name ____ Name ____

5. Information:

Physician Name: __________________________ Full Address (City/St) ____ Phone __________________
Dentist Name: ___________________________ Full Address (City/St) ____ Phone __________________
Date of Last Tetanus (DPT)________________ Known Allergies ___________________________ Present Medication _______________________________
Insurance Company ____ Policy Holder's I.D. ____

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Signatures of Parents/Guardians Date **(In Effect for 1 Year)** E-Mail Address