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 **Physician**_____ at_____ **(phone #)** or **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. _____

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