THE COMMONWEALTH OF MASSACHUSETTS Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name:		
Address: Phone Number:		
Child's Allergies:		
Chronic Health Conditions:		
Emergency Contacts (In order to be contacted) Name		
Address		
Relationship to child		
Home Phone Cell Phone		
Do you give permission for child to be released to this perso	n? Yes	No
Name		
Address		
Relationship to child		
Home Phone Cell Phone Do you give permission for child to be released to this perso		
Do you give permission for child to be released to this perso	n? Yes	No
Name		
Address		
Deletionship to shild		
Home Phone Cell Phone		
Do you give permission for child to be released to this perso	n? Yes	No
Health Insurance Coverage	Policy #	
Parent/Guardian Name:	Phone	_Cell
Parent/Guardian Name:	Phone	_ Cell
Parent /Guardian Signature	Date (valid f	or one vear)

Parent /Guardian Signature

Date (valid for one year)