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 person? Yes_____ No_____

Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____ Do you give permission for child to be released to this person? Yes_____ No_____

Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____ Do you give permission for child to be released to this person? Yes_____ No___

Parent Signature _____

Date _____ Valid for one year

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