HUTCH kids Child Care Center

CONSENT FOR EMERGENCY TREATMENT & MEDICAL INFORMATION

Child's Name:	DOB:

Please fill out ALL boxes with complete information or NA if not applicable.

MEDICAL INFORMATION:

Child's Physician:	Phone:

Street:	City:	Zip Code:

Child's Dentist:	Phone:

Street:	City:	Zip Code:

Date of Child's Last Physical Exam:
Date of Child's Last Tetanus (or DTP) Immunization:
Known Allergies (Please list or write NONE):

INSURANCE INFORMATION:

Medical Insurance:	Insurance #:
Preferred Hospital:	

Street:	City:	Zip Code:

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Child's Name:	DOB:

I hereby give my permission that my child, _____, may be given emergency treatment by a qualified staff member of **Hutch Kids Child Care**.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event I cannot be contacted, I further give my consent to the medical, surgical and hospital personnel to provide care and treatment, and to administer necessary procedures when deemed immediately necessary or advisable to safeguard my child's health.

Parent's Name:	Work Phone:
Cell Phone:	Home Phone:
Parent Signature:	Date:

Parent's Name:	Work Phone:
Cell Phone:	Home Phone:
Parent Signature:	Date:

Please indicate the best number to reach each parent by with an (*)