# CONSENT FOR EMERGENCY MEDICAL TREATMENT-
## Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____
DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE | WORK PHONE
( ) | ( )

LIC 627 (ENG/SP) (5/01) (CONFIDENTIAL)

TE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING


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| | |
|---|---|
| Name Of Child: | Physician's Name: |
| Address: Phone: | Physician's Phone: |
| Days: Teacher: | Health Insurance Name and Policy Number: |
| Parents Daytime Address and Phone Number<br>Mother: Phone: | Dentist's Name:<br>Dentist's Phone: |
| Father: Phone: | Dental Insurance Name and Policy Number: |
| Other Emergency Contact (outside of area):<br>Name: Phone: | Medical Problems or Needs: |
| Authorized Release To:<br>Name: Phone: | |
| Name: Phone: | |
| Name: Phone: | |
| Parents Signature: | |

| | |
|---|---|
| Name Of Child: | Physician's Name: |
| Address: Phone: | Physician's Phone: |
| Days: Teacher: | Health Insurance Name and Policy Number: |
| Parents Daytime Address and Phone Number<br>Mother: Phone: | Dentist's Name:<br>Dentist's Phone: |
| Father: Phone: | Dental Insurance Name and Policy Number: |
| Other Emergency Contact (outside of area):<br>Name: Phone: | Medical Problems or Needs: |
| Authorized Release To:<br>Name: Phone: | |
| Name: Phone: | |
| Name: Phone: | |
| Parents Signature: | |