

Little Lambs Preschool

Emergency Medical Treatment Authorization

Child's full name _____ Date of birth _____
Name child is to be called _____

I, _____, parent or guardian of the child named above, give my permission to Little Lambs Preschool to secure and authorize such emergency medical care and treatment as my child might require while under the Provider's supervision. I also authorize the Provider to administer emergency care of treatment as required, until emergency medical assistance arrives. I also agree to pay all the costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

Note: Every effort will be made to notify parents *immediately* in case of emergency.
In the event of an emergency, it would be necessary to have the following information.

Name of Parent or Legal Guardian: _____
Address: _____
Home phone: _____ Work: _____ Cell: _____
Name of Parent or Legal Guardian: _____
Address: _____
Home phone: _____ Work: _____ Cell: _____

Doctor: _____ Ph.# _____
Address: _____
Preferred Hospital to Contact: _____ (Trinity Regional) Ph.# _____
Address: _____

Dentist: _____ Ph.# _____
Address: _____

Person(s) to contact in as emergency if parents are unavailable:
Name Home# Work#/Cell# relationship

Child Care Provider: _____ Ph.# _____

Present medication(s): _____
Known allergies: _____
Date of last tetanus: _____ Religious preference: _____

Insurance provider & number: _____

I give permission for Little Lambs Preschool to apply sunscreen and insect repellent as needed.

Parent/Guardian signature _____ Date _____

Preschool staff are the only ones who have access to this information.