EMERGENCY MEDICAL CONSENT FORM

_____ has my permission to obtain emergency medical treatment for my child, _____ when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

Mother/Guardian's Name
_____

Home Phone _____ Cell Phone _____

E-mail Address:
_____

Father/Guardian's
Name_____

Home Phone _____ Cell Phone _____

E-mail Address: _____

My insurance provider is _____

My child's medical record number is _____

Preferred hospital/treatment center _____

My child is taking the following medications

_____ _____ _____

My child has the following allergies _____ _____
_____

I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in Mayr's Little Lambs care.

_____ _____ Signature of Parent or Guardian Date

_____ _____ Signature of Parent or Guardian Date