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			
Relationship to child Home Phone Cell Phone De you give permission for child to be released to this per			
Do you give permission for child to be released to this pers	son? Yes	No	
Name			
Address			
Relationship to child Cell Phone			
Do you give permission for child to be released to this pers	son? Yes	Νο	
Name			
Address			
Relationship to child			
Home Phone Cell Phone			
Do you give permission for child to be released to this pers	son? Yes	No	
Health Insurance Coverage	Policy #		
Parent/Guardian Name:	Phone	Cell	_
Parent/Guardian Name:	Phone	Cell	_
Parent /Guardian Signature	Date (valid for one year)		