EMERGENCY CARD

(Please fill in both cards)

Name of child _____
Name of parent _____

*Phone numbers to call in the event of an emergency
_____
_____

*Name(s) of person(s) who may be contacted in the event of an emergency or illness if you cannot be reached:
Name: _____ Phone: _____
Name: _____ Phone: _____

*Physician: _____ Phone: _____

In the event of an emergency, if I cannot be reached _____ has my permission to authorize treatment for my child.

Signature of parent or guardian _____ Date: _____

EMERGENCY CARD

(Please fill in both cards)

Name of child _____
Name of parent _____

*Phone numbers to call in the event of an emergency
_____
_____

*Name(s) of person(s) who may be contacted in the event of an emergency or illness if you cannot be reached:
Name: _____ Phone: _____
Name: _____ Phone: _____

*Physician: _____ Phone: _____

In the event of an emergency, if I cannot be reached _____ has my permission to authorize treatment for my child.

Signature of parent or guardian _____ Date: _____

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

AS THE PARENT, DOMESTIC PARTNER, 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
( )	( )

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

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HOME PHONE	WORK PHONE
( )	( )

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