



Authorization for Emergency Medical Care

Child _____ Birth Date _____

Parents/Guardians:

Name	Home Phone	Work Phone	Cell Phone

Street Address _____ Town _____ Zip Code _____

Allergies _____ Date of Last Tetanus _____

Insurance Carrier _____ Insurance ID _____

Physician _____ Phone _____

Dentist _____ Phone _____

Emergency Medical Contacts (other than parents) who have permission to transport our child in the event of an emergency:

Name	Relationship	Home Phone	Work Phone	Cell Phone

In the event of a medical emergency we hereby authorize Tolland Cooperative Preschool teacher to provide first aid, and/or request emergency medical treatment for our child. We authorize our child to be transported to the nearest hospital, medical, or dental facility by ambulance to obtain treatment. The Tolland Cooperative Preschool helping parent will accompany our child to the emergency facility in the ambulance and will provide a copy of this form and the Child Health Record for the emergency medical care staff. Any hospital or emergency medical care personnel are authorized to treat our child pursuant to the applicable medical standards of care and to consult the physician or dentist listed above. We understand that we will be notified of the emergency situation immediately and if we cannot be reached we grant permission for a person on our emergency contact list to make decisions for our child until one of us responds. We will be responsible for all medical charges.

Signature

Signature

Printed Name

Printed Name

Date

Date