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 Home Phone Cell Phone

Do you give permission for child to be released to this person? Yes No

Name Address Relationship to child

Home Phone Cell Phone

Do you give permission for child to be released to this person? Yes No

Name Address Relationship to child

Home Phone Cell Phone

Do you give permission for child to be released to this person? Yes No

Health Insurance Coverage Policy # Parent/Guardian Name: Phone Cell

Parent/Guardian Name: Phone Cell

Parent /Guardian Signature Date (valid for one year)