AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If you have already submitted this form, we do not need another one unless information has changed.
This information may be needed by a medical doctor and/or medical facility not having access to your child's medical history.

I am the Parent/Guardian of _____ Date of Birth_____

CURRENT HEALTH INFORMATION

Child's Current Weight _____ Allergies (list all)_____
Current Medications _____
Any pertinent facts to which a medical doctor should be alerted_____
Past Illnesses and Injuries_____

INSURANCE INFORMATION

Insurance Company _____ Policy number _____
Policy holder's name _____

EMERGENCY INFORMATION

Father/Guardian	Mother/Guardian
Name _____	Name _____
Address _____	Address _____
City, Zip _____	City, Zip_____
Phone _____ work _____	Phone _____work _____
Cell Phone _____	Cell Phone _____

If I cannot be reached in the event of any Emergency, the following person is authorized to act on my behalf:
Name _____ Phone _____ Relationship _____
Preferred Medical Doctor/Medical Facility _____ Phone _____

HEALTH CARE PLAN FOR CHILDREN WITH MANAGED MEDICAL CONDITIONS AND ALLERGIES

Describe the health care needs of this child and the plan of emergency care as identified by the parent and heath care provider, including SYMPTOMS and MEDICINES that will be left at the school:

_____
_____
_____
MEDICAL CONDITION: _____
ASTHMA: _____
ALLERGIES: _____

Subject to the conditions set forth below, I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity at the preschool or while on any field trip sponsored by Oak Hill Preschool. I give permission for my child to attend such field trips.
Should a medical emergency arise during my child's participation at OHP, I understand every effort will be made to contact me at the phone numbers listed above. If it is believed my child's life or health may be at risk, 911 will be called and I consent to:

(i) The administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility identified above, or chosen by the 911 rescue squad; and
(ii) the immediate administration of life-sustaining measures deemed necessary under the circumstances

I agree to release, indemnify and hold harmless any OHP staff members, OHP Officers, or agents from any lawsuit, claim, expense, demand or action against anyone in charge of my child at the time the emergency occurs.

_____ _____
Signature of Parent/Guardian **Date**

Rev. Date 07/19/2021