

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information may be needed by a medical doctor and/or medical facility not having access to your child's medical history. **Please write clearly.**



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 _____

CONTACTS

Father/Guardian

Name _____

Address _____

City, Zip _____

Phone _____

Employer _____

Work Phone _____

Mother/Guardian

Name _____

Address _____

City, Zip _____

Phone _____

Employer _____

Work Phone _____

If parents cannot be reached in the event of any Emergency, the following people are authorized to act on my behalf **(must provide 2 contacts other than parents/guardians):**

Contact 1

Name _____

Address _____

City, Zip _____

Phone _____

Relationship _____

Contact 2

Name _____

Address _____

City, Zip _____

Phone _____

Relationship _____

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 health care provider:

MEDICAL CONDITION: _____

ASTHMA: _____

ALLERGIES: _____

EMERGENCY AUTHORIZATION

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