|  |  |  |
| --- | --- | --- |
|  **Child’s Name:** |  **Date of Birth:** |  **Home Phone #:** |
|  |  |  |
| **Mother/Guardian Name:** | **Phone #:** | **Work address** |
| Email: | Work:Cell: | Work Hours: |
| **Father/Guardian Name:** | **Phone #:** | **Work Address:** |
| **Email:** | Work:Cell: | Work Hours: |
| **Please list emergency names:**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. | **Phone #:**Work:Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:Cell: | **Home Address:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Child’s Medical problems/allergies**\*Please indicate if your child needs an inhaler, Epi-pen, or other medications for allergies | **Physician’s name and #****Choice of the Hospital:** | **Medical Insurance Provider and Insurance Policy #** |

This form was completed by (relationship to a child): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Consent and Agreement for Emergencies**:

In the event of a serious accident or injury to a child enrolled in our program, it is our policy to **call 911** and notify the parent or guardian. It is possible that I/we will not be able to locate the parent or guardian immediately, therefore it is necessary to obtain parent /guardian authorization for medical emergency treatment in the parent’s or guardian’s absence. This authorization is kept on file, and in case of a serious accident when the parent or guardian cannot be reached, the statement of consent will be taken to the hospital with the child.

* **I give consent** to have my child receive first aid by Yelena Pasternak, the Care Provider, and if necessary to transported to receive emergency care. I understand I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above **to act on my behalf** until I am available. I agree to review and update this information whenever a change occurs and at least every six months.
* **Refusal to Grant Permission**:

In the event that I cannot be reached to make arrangement for emergency medical /dental care for my child, **I DO NOT** grant my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to take my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to the nearest hospital or medical facility for the treatment for any accident or illness as deemed necessary by the provider. Instead, I wish the following action to be taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_