



PARENTAL CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, I (we), in the event of my (our) unavailability, hereby authorize the faculty and staff of Piccoli Bambini Preschool to grant permission for any medical or surgical treatment by the medical staff or by the physician at the nearest hospital in our area, if any, designated at the bottom of this form, on behalf of my (our) child.

Child's Name: _____ Date of Birth: _____

Parent(s) or emergency contact individual, designated on the Student Information form, will be notified if the child becomes ill at school. Parents will then come to school or have the emergency contact individual come to school to collect the child. The teacher, or director, can administer no medication, unless a doctor and the parent provide written permission and directions prior to administration of medication.

Parental Signature Print Name Day Phone Cell Phone

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Known Allergies: _____

Known Illnesses: _____

Daily Medications: _____

Pediatrician Name; _____

Pediatrician Telephone Number: _____

Health Insurance Company: _____

Insurance Policy/Contract #: _____

Subscriber Name: _____

Subscriber's Employer (if insurance is thru a business): _____