Zadie's NURTURING DEN
SUMMIT • THE ORANGES

Emergency Medical Treatment and Transportation Form

In the event that your child is transported to a clinic or hospital, this for will be taken to provide the hospital with the copy of your child's insurance card.

Child's Name:		Home Phone Number:		
Child's Age:	DOB:	Gender: ☐ Male ☐ Female	Blood Type:	
Mailing Address:		City:	State:	Zip:
Medical Problems:		Allergies:		
Child's Medical Insurance Plan: (Please provide a copy of insurance card)				
Carrier:		Phone Number:		
Policy Number:		Policy in Name of:		
Physician's Name:		Office Phone:		
Dentist's Name:		Office Phone:		

PARENT #1	
Name:	Place of Employment:
Work Phone:	Cell Phone:

PARENT #2	
Name:	Place of Employment:
Work Phone:	Cell Phone:

EMERGENCY CONTACT (OTHER THAN PARENTS & PHYSICIAN)	
Name:	Relationship:
Work Phone:	Cell Phone:

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above childcare center director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in an emergency:

1. The parent/guardian will ne contacted immediately.
2. The child's health care provider will be contacted.
3. We will attempt to contact the parent through all of the emergency contacts listed above.
4. If we cannot contact the parent/guardian or your child's health care provider, we will do any or all of the following:
    a. Call for emergency first aid assistance/transportation.
    b. Call another health care provider.
    c. Have the child transported to an emergency hospital in the company of a staff member.

Parent's/Guardian's Signature: _____ Date: _____

Witness: _____ Date: _____