

EMERGENCY TREATMENT CONSENT FORM



Date: _____

As parent, agency representative or legal guardian, I here by give consent to Kirk House Preschool Saratoga to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S .) for (child's name) _____. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

- I understand that no guarantees have been made to me as to the effect of such treatment on my dependent's condition.
- I acknowledge responsibility for all reasonable charges in connection with transportation, care and treatment given during this period.
- I further authorize the school to have my dependent released into the custody of its representative, should hospital care no longer be required.
- I understand that the school will not be responsible for anything that may happen as a result of false information given at the time of enrollment.
- The school will not assume responsibility for a child who has not been signed in upon arrival for class.

In the case of a medical emergency while my child is attending Kirk House Preschool, I understand that the following procedure will be followed:

- The school will contact parents/guardians or agency representative.

Mother can be reached at _____ or _____

Father can be reached at _____ or _____

Guardian can be reached at _____ or _____

Agency representative can be reached at _____

- If parent, guardian or agency representative is not available, the school will contact these emergency persons:

Name _____ Phone _____

Name _____ Phone _____

- The school will arrange for emergency transportation to the nearest emergency medical facility, if necessary. The dependent will be transported by an ambulance or other such vehicle when necessary.

- The school will contact dependent's physician or dentist .

Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Dependent's allergies, if any: _____

Date of last tetanus booster _____

Medicines dependent is taking _____

Name of health insurance carrier _____

Group number _____

Name of dental insurance carrier _____

Group number _____

Signature of parent(s), guardian(s), or agency representative:

_____ Date _____

_____ Date _____

Home address _____