CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO LITTLE GREEN SPROUTS PRESCHOOL TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR _____.

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____

CHILD HAS THE FOLLOWING MEDICAL CONDITIONS:

_____

PARENT/GUARDIAN'S NAME (PRINT): _____
DATE: _____

SIGNATURE: _____

HOME ADDRESS: _____

HOME/CELL PHONE: _____ WORK PHONE: _____

PARENT/GUARDIAN'S NAME (PRINT): _____
DATE: _____

SIGNATURE: _____

HOME ADDRESS: _____

HOME/CELL PHONE: _____ WORK PHONE: _____