CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

SPECTRUM PRESCHOOL TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

1. _____

CIRCLE ONE: MILD MODERATE SEVERE

TREATMENT: 1._____ 2. _____ 3: _____

2. _____

CIRLCE ONE: MILD MODERATE SEVERE

TREATMENT: 1._____ 2. _____ 3. _____

CHILD HAS THE FOLLOWING FOOD ALLERGIES:

1._____

CIRCLE ONE: MILD MODERATE SEVERE

TREATMENT: 1. _____ 2. _____ 3. _____

2._____

TREATEMENT: 1._____ 2. _____ 3. _____

OTHER ALLERGIES: _____

CIRCLE ONE: MILD MODERATE SEVERE
TREATMENT: 1. _____ 2. _____ 3. _____

_____ _____
DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )