



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 Little Stars of Bethlehem Early Learning Center to grant permission for any medical or surgical treatment deemed necessary by the medical staff at Prince William Hospital, or by the physician designated at the bottom of this form, on behalf of my/our child.

Child's Name: _____

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 sick child. The teacher/director can administer no medications, unless a doctor and the parent provide written permission and directions prior to administration of such medication.

Parental Signature Print Name Day Phone Cell Phone

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Known Allergies: _____

Known Illnesses: _____

Daily Medications: _____

Date of last DtaP shot _____

Pediatrician Name: _____

Pediatrician Telephone Number: _____

Health Insurance Company: _____

Insurance Address: _____

Policy/Contract #: _____

Subscriber Name: _____

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