bellevue montessori school

Consent for Emergency Treatment

Name of Child: ______________________________________Date of Birth______________

Name of Parents: ____

Consent for Emergency Treatment:

Child's Physician ______________________ Phone ___-____-_______

Child's Dentist ________________________ Phone ___-____-_______

Preferred Hospital _____________________ Phone ___-____-_______

Date of Last Physical or Doctor's visit ___________________ (must be within 2 years)

Child's Allergies and Medical Conditions: ____

____

____

____

____

Allergies require your child's health care provider to complete and sign a Report of Food Allergy. All other medical conditions require your child's health care provider to complete a Health Care Plan or Child Asthma Plan as applicable. Parents must provide their child's snacks when food allergies exist.

I hereby give permission for my child _________________________ to be given emergency treatment by a qualified staff member of Bellevue Montessori School. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physicians to safeguard my child's health.

Parent's Signature ______________________________ Date _______________