



The Center for the Development of Children

4 Springdale Ave.
PO Box 279
Dover, MA 02030

Sandy Blinn, Director

(508)785-1835

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program that is trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to secure necessary medical treatment for my child.

Child's Physician Name: _____

Address: _____

Phone Number: _____

Child's Allergies: _____

Chronic Health Conditions: _____

Emergency Contacts *(In order to be contacted)*

Name _____

Address _____

Relationship to child _____

Home Phone _____ Cell Phone _____

Do you give permission for child to be released to this person? Yes ___ No ___

Name _____

Address _____

Relationship to child _____

Home Phone _____ Cell Phone _____

Do you give permission for child to be released to this person? Yes ___ No ___

Name _____

Address _____

Relationship to child _____

Home Phone _____ Cell Phone _____

Do you give permission for child to be released to this person? Yes ___ No ___

Health Insurance Coverage _____	Policy # _____
Parent/Guardian Name: _____	Phone _____ Cell _____
Parent/Guardian Name: _____	Phone _____ Cell _____

Parent /Guardian Signature

Date (valid for one year)