The Center for the Development of Children
30 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)_____