

EMERGENCY MEDICAL TREATMENT FOR MINORS DURING SCHOOL HOURS AT HARVEY BROWNE PRESCHOOL

Child's Name _____ Birth date _____

Medications child is taking _____

Allergies (food and drugs) _____

Name of Parents/Guardians _____
(Persons legally responsible for the child)

Address _____ Zip _____

Home Phone _____ Office Phones (mom) _____
(dad) _____

Cell Phones, Pagers or other #s where I can be found (mom) _____
(dad) _____

Someone who will know where to find me _____ Phone _____

Family Physician _____ Phone _____

If I cannot be located by the above means, please contact the following persons in the event of an emergency. These persons are also authorized to pick up my child from school.

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____

Name _____ Phone _____

Relationship to child _____

Please turn page over

Health Insurance company _____ Policy # _____

Emergency Treatment Authorization: In case of a medical emergency involving the minor listed above. I request the doctor/dentist/hospital staff to contact me or my spouse at the numbers provided. In the event that my spouse or I cannot be reached, I grant written permission to Barbara Bailey, Director of Harvey Browne Preschool, or her designee to release health information to medical personnel; otherwise it will be kept confidential. I grant written permission to Barbara Bailey or her designee to authorize the appropriate medical/dental/hospital personnel to render emergency medical treatment deemed appropriate if my spouse or I cannot be reached. Children transported in an emergency will be taken to Baptist East Hospital. I (we) agree to pay for the treatment or medication received by said child, and release Harvey Browne Preschool from all claims or liability arising from said emergency medical treatment.

Signature _____ Date _____

Witness _____ Date _____