faith
COMMUNITY MINISTRIES

Faith Community Infant Care

EMERGENCY TREATMENT RELEASE AND MEDICAL AUTHORIZATION FORM

FAMILY INFORMATION		
Name of Child:		Weight:
Home Phone: ( )		Birth Date: Age:
Father's Name:	Work Phone: ( )	Cell Phone: ( )
Mother's Name:	Work Phone: ( )	Cell Phone: ( )
Do you have legal custody and/or guardianship of this child? [ ] No [ ] Yes		
If you answered no, please list those who do have custody and/or are legal guardians:		
Name:	Address:	
	Home Phone: ( )	Work Phone: ( )
Are there any special custodial conditions you want to make us aware of?		

MEDICAL INFORMATION		
Dosage is determined according to the age and the weight of the child.		
Family Physician:		Phone Number: ( )
Is your child insured? [ ] No [ ] Yes		Insurance Provider:
Insurance Group #	Policy #	Insurance Phone: ( )
Specify medical allergies, chronic illnesses, asthmatic conditions, or any other special health conditions of your child, if any:		

MEDICAL AUTHORIZATION		
[ ] No [ ] Yes Children's chewable non-aspirin pain reliever (acetaminophen) (those who can't swallow)		
This medication is to be given for the following reason(s):		
Special instructions:		

LOCAL EMERGENCY CONTACTS		
Please list three adults who, in the case of an emergency, will assume responsibility for your child if you cannot be reached.		
Name:	Relationship:	
	Day Phone: ( )	Cell Phone: ( )
Name:	Relationship:	
	Day Phone: ( )	Cell Phone: ( )
Name:	Relationship:	
	Day Phone: ( )	Cell Phone: ( )

AUTHORIZATION FOR EMERGENCY TREATMENT

As a parent and/or guardian, I authorize the treatment by a qualified and licensed medical doctor for the above named minor in the event of a medical emergency which, in the opinion of the attending physician, is needed to prevent endangerment to his/her life, disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. Necessary first aid may be given at school. This release form is being completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature of Parent or Guardian *Date*

Name of Person Completing Form *Relationship*