AUTHORIZATION FOR EMERGENCY MEDICAL CARE & PARENTAL HEALTH STATEMENT

COMMUNITY OF FAITH PRESCHOOL

Child's Name: (Last)_____ **First**_____

Child's Birth Date: _____ Cell Phone Number _____

Home Address_____ City_____ Zip_____ State _____

1. In the event the parents/guardians cannot be reached to make arrangements for **emergency medical care** for my child at the time of an illness/accident, I fully authorize COF and its staff to obtain any necessary emergency medical care at the nearest facility even one that I did not list below.
2. I state my child has been examined within the past year by the Physician and he has stated that my child is able to participate in a preschool program.

NAME OF PHYSICAN _____

Address _____ Phone # _____

NAME OF HOSPITAL _____

Address _____ Phone # _____

Health Insurance Provider_____ Account/ID#_____

Health Insurance Phone # _____

Dentist Name _____ Dentist # _____

List of any **allergies**, special needs, existing illnesses, previous serious illnesses, injuries and/or hospitalization during the past 12 months, medication prescribed for long-term use, **epi-pen** prescribed, any possible reactions to medication they may be taking or need in an emergency, any other information which emergency medical personnel should be made aware of:

(Please write "NO KNOWN ALLERGIES" and initial if there none)

_____

_____

EPI PEN (the FARE Form must be signed by the Physician if this is kept at school)

Does your child have a prescribed Epi Pen-Initial One YES _____ NO_____

If YES, for:

_____

_____ _____ _____

Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian Date