THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Meeting House Preschool
162 Main Street P.O. Box 761 East Orleans MA 02643
508-255-8793

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are 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 CAPE COD HOSPITAL

Emergency Contacts (*In order to be contacted*)

1. Name_____ Relationship to child_____
Address_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

2. Name_____ Relationship to child_____
Address_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

3. Name_____ Relationship to child_____
Address_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

4. Name_____ Relationship to child_____
Address_____
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

_____ _____
Parent /Guardian Signature Date (valid for one year)

SG/LG/SAEmergencyMedicalConsent20100122