Quality Time Learning Center

MEDICAL CARE AND EMERGENCY CONTACT INFORMATION

Child's Name: _____ D.O.B._____

Address: _____

Mother's Name: _____ (H) _____ (W) _____

Father's Name: _____ (H) _____ (W) _____

Alternate Emergency Contact:
Name: _____ (H) _____ (W) _____

Name: _____ (H) _____ (W) _____

Child's Physician: _____ (Ph)_____

Family Physician: _____ (Ph) _____

Child's Medical History:
Known allergies of child (medicine, food, etc.):
1._____ 3._____

2._____ 4. _____

Describe past serious illnesses or hospitalization, with date:

_____

_____

Medications taken by child at this time:

1._____ 3. _____

2. _____ 4._____

Describe all physical conditions or illnesses which could affect the child's participation in the programs or medically diagnosed conditions which prohibit participation in normal day care activities (diabetes, epilepsy, insufficient blood coagulation, etc.):
_____
_____

EMERGENCY MEDICAL TREATMENT CONSENT
(Must Be Notarized)

I herby give Quality Time Learning Center permission to provide first aid care as deemed necessary for my child, _____. In the event I/We cannot be reached, I hereby authorize Quality Time Learning Center to transport my child to the emergency room of the hospital(s) listed below. I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which the physician deems necessary (including anesthesia). I have specified any hospital(s) below, my child may be taken to and/or the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred. Nearest Hospital: ***Holy Cross*** Alternate _____

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

of _____, County of _____

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____day of _____, 20 _____

NOTARY PUBLIC_____ My Commission Expires: _____