STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

**Child Care Centers Or Family Child Care Homes**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ . THIS CARE MAY BE GIVEN UNDER

NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

|  |  |  |
| --- | --- | --- |
| CHILD HAS THE FOLLOWING MEDICATION ALLERGIES: |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| DATE |  | PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE |
| HOME ADDRESS |  |  |
| HOME PHONE | WORK PHONE |  |
| ( ) | ( ) |  |

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