CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

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

Autumn Creek Learning Center
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

LIC 627 (5/01) (CONFIDENTIAL)

CONSENT TO A MEDICAL EXAMINATION

I _____ do hereby consent
(CLIENT/RESIDENT, PARENT, AUTHORIZED REPRESENTATIVE)

to a physical examination of _____
(CLIENT/RESIDENT)

by a physician designated by the State Department of Social Services and also consent to any laboratory tests associated with the medical examination for the purpose of investigating the possible abuse or neglect of

_____.
(CLIENT/RESIDENT)

_____
(SIGNATURE OF AUTHORIZING PERSON)

_____
(RELATIONSHIP TO CLIENT/RESIDENT—IF OTHER THAN CLIENT/RESIDENT)

_____
(ADDRESS)

_____
(CITY/STATE/ZIP CODE)

LIC 627A (11/89)