

Longwood Medical Area Child Care Center

Emergency Consent Form

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 LMACCC to transport my child to Boston Children's Hospital and to secure for my child the necessary treatment including anesthesia. I understand the teachers in LMACCC are trained in the basics of First Aid and I authorize them to give my child First Aid when appropriate.

Home Number: _____ Work Number: _____

Pediatrician or Health Clinic:

Address:

Telephone:

Emergency Contacts

The following relative or friends should be contacted if I am unavailable in an emergency. I also authorize the LMACCC to release my child to their custody when I cannot be reached.

1. _____

Name, Address, Telephone

2. _____

Name, Address, Telephone

3. _____

Name, Address, Telephone

Name

Date