Longwood Medical Area Child Care Center

GROUP CHILD CARE AND SCHOOL AGE CHILD CARE
FIRST AID AND EMERGENCY MEDICAL CARE
CONSENT FORM
102 CMR 7.09(3)

Child's Name: ______________________________ Date of Birth: __________________

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid 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________________________, and to secure necessary medical treatment for my child.

Child's Physician Name: ____
Address: ____
Phone Number: ____________________

Child's Allergies: ____
Chronic Health Conditions: ____

Emergency Contacts (*In order to be contacted*)

1. Name: ______________________ Address: ______________________
Relationship to Child: ______________________ Phone #: ______________________
Do you give permission for child to be released to this person? Yes No

2. Name: ______________________ Address: ______________________
Relationship to Child: ______________________ Phone #: ______________________
Do you give permission for child to be released to this person? Yes No

3. Name: ______________________ Address: ______________________
Relationship to Child: ______________________ Phone #: ______________________
Do you give permission for child to be released to this person? Yes No

Health Insurance Coverage:		Policy #:
Parent(s) Name:	Phone(w)	Phone (h)
Parent(s) Name:	Phone(w)	Phone (h)

______________________________ ______________________
Parent/Guardian Signature **Date**

395 Longwood Avenue, Boston, MA 02215 • Telephone: 617-632-2755 Fax: 617-632-2724
Email: kquinn@masco.harvard.edu