EMERGENCY MEDICAL CONSENT FORM

MULTILINGUAL ACADEMY has my permission to obtain emergency medical treatment for my child, _____ when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

Mother/Guardian's Name _____

Home Phone _____ Cell Phone _____

E-mail Address: _____

Father/Guardian's Name_____

Home Phone _____ Cell Phone _____

E-mail Address: _____

My insurance provider is _____

My child's medical record number is _____

Preferred hospital/treatment center _____

My child is taking the following medications

_____ _____ _____

My child has the following allergies

_____ _____ _____

PLEASE WRITE YOUR INITIALS:

☐ I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in child care.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Parent or Guardian Date