The Commonwealth of Massachusetts

Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child’s Name: Date of Birth:

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that a parent will be contacted in the event of an emergency requiring medical attention for my child. However, if a parent cannot be reached, I hereby authorize the program to call my pediatrician, the school’s consulting pediatrician, Dr. Margaret Carolan at Cohasset Pediatrics and/or the Scituate Fire Department to transport my child to the nearest medical facility and/or to and to secure necessary medical treatment for my child.

Parent/Guardian Signature Today’s Date (valid for one year)

Child’s Physician Name:

Address:

Phone Number:

Child’s Allergies:

Chronic Health Conditions:

**REQUIRED: EMERGENCY CONTACTS WHO ARE IMMEDIATELY AVAILABLE TO PICK UP MY CHILD IN THE EVENT OF ILLNESS OR INJURY.**

Name:

Address:

Relationship to child:

Home Phone: Cell Phone:

Do you give permission for child to be released to this person? Please circle: Yes No

Name:

Address:

Relationship to child:

Home Phone: Cell Phone:

Do you give permission for child to be released to this person? Please circle: Yes No

Name:

Address:

Relationship to child:

Home Phone: Cell Phone:

Do you give permission for child to be released to this person? Please circle: Yes No

Health Insurance Coverage Policy #

Parent/Guardian name Phone Cell

Parent/Guardian name Phone Cell

Packet/First Aid and Emergency Medical Care Consent Form.doc updated 3/2023