

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 at Erdman Preschool who are trained in the basics of first aid/CPR to give my child first aid/CPR 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)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone/Cell Phone: \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone/Cell Phone: \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

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Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone/Cell Phone: \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Health Insurance Coverage: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone/Cell: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone/Cell: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date (valid for one year)