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 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 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: _____

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? 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 _____