MEDICAL RELEASE FORM

Child Information

First Name _____ Last Name _____

Nick name _____Date of Birth _____

Parent Guardian

First Name _____ Last Name _____

Home Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

Person to contact if no answer:

Name _____Phone _____

Insurance carrier & policy number _____

Doctor's name & phone number_____

Dentist's name & phone _____

Does your child have any medical conditions that the emergency room would need to know about (such as asthma, diabetes, epilepsy?) Yes No

Is your child on any medication? Yes No

If yes, what is the name of the medication? _____

I hereby authorize the Little Stars Child Development Center or any of its employees to call a physician to secure necessary medical care in the event of an emergency. I give consent for all medical and/or surgical treatment that may be required for our child during my absence I hereby authorize the Little Stars Child Development Center to have my child as listed above treated by any medical personnel, EMTs, paramedics, doctors or dentist that the Little Stars Development Center thinks is necessary (including the administration of anesthesia if surgery is advised by a physician), and to otherwise act in my behalf in order to protect my child when I cannot be reached and/or when delay would be dangerous in case of illness or accident. I also give my consent to have my child transported by ambulance to a medical facility. I understand that I will be responsible for all costs related to such treatment.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on my child's condition. I have read this form and I certify that I understand its contents.

I hereby give my consent:

Parents Signature _____ Date _____

(This consent expires when above child no longer attends the Little Stars Child Development Center)