Consent for Emergency Medical Treatment

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name(s): _____

Primary Phone Number: _____

Alternate Phone Number: _____

Child's Physician Name: _____

Physician Phone Number: _____

Preferred Hospital: _____

In the event that I cannot be reached to make arrangements for emergency medical attention, I hereby authorize My Piccolo Mondo Daycare to take my child to the above-named physician or to the nearest hospital for necessary medical treatment. I give consent for emergency medical care to be administered to my child by a licensed healthcare provider.

I understand that I am responsible for all costs incurred as a result of emergency medical treatment. This authorization is valid as long as my child is enrolled in My Piccolo Mondo Daycare.

Parent/Guardian Signature: _____

Date: _____