Emergency Medical Consent

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name (if parent is not available): _____

Phone: _____ Relationship to Child: _____

Child's Physician: _____

Phone: _____ Address: _____

Preferred Hospital: _____

Insurance Provider: _____

Policy Number: _____

Medical Conditions or Allergies: _____

Consent Statement:

In the event that I, the parent or legal guardian, cannot be reached in an emergency, I authorize My Piccolo Mondo or its designated representative

to obtain necessary medical treatment for my child. I understand that this authorization includes transporting my child to a medical facility and

authorizing any medical or dental treatment deemed necessary by licensed medical professionals.

Parent/Guardian Signature: _____

Date: _____