
**EMERGENCY MEDICAL TREATMENT AND TRANSPORTATION PERMISSION FORM**

Child's Name:_____

**Emergency Medical Treatment**
I, the parent or legal guardian of my child listed above, hereby authorize emergency medical treatment for my child in the event that I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

**Emergency Transportation**
I, the parent or legal guardian of my child listed above, hereby give permission for my child to be transported with his/her caregiver and/or the Owner/Administrator or Curriculum Coordinator of Beginnings and Beyond, should a medical emergency arise and transportation to a medical facility be required.

Name of Child's Physician:_____

Physician's Address:_____

Physician's Phone Number:_____

Physician's Office Hours:_____

Special Medical Information (allergies, etc.):_____

Parent/Guardian's Signature_____ Date_____