



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 one of the Office Staff 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 _____