FAMILY'S MEDICAL INFORMATION AND
PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

CHILD 1 NAME: _____

General Allergies _____

Allergies to Medication(s) _____

Other Medical Problems, Conditions or Special Needs_____

Are any of the allergies or condition(s) described above serious, chronic, or life threatening, or will they require any special care during program hours? ____ yes ____ no

If yes, please elaborate*_____

_____

CHILD 2 NAME: _____

General Allergies _____

Allergies to Medication(s) _____

Other Medical Problems, Conditions or Special Needs_____

Are any of the allergies or condition(s) described above serious, chronic, or life threatening, or will they require any special care during program hours? ____ yes ____ no

If yes, please elaborate*_____

_____

CHILD 3 NAME: _____

General Allergies _____

Allergies to Medication(s) _____

Other Medical Problems, Conditions or Special Needs_____

Are any of the allergies or condition(s) described above serious, chronic, or life threatening, or will they require any special care during program hours? ____ yes ____ no

If yes, please elaborate*_____

_____

Please note:** This may require the completion of a **Special Health Care Needs Plan** by your medical provider Children with chronic or life-threatening allergies or other medical conditions which may require administration of medication, special training of staff, or other special care by HCC, ***must have a special care plan completed by a health care provider **before** participating in the program. ***This may delay entrance into the program, so please plan accordingly.***

PHYSICIAN INFORMATION

Child's Primary Medical Provider _____ Phone _____

Address _____

Other Medical Provider (if relevant) _____ Phone _____

INSURANCE INFORMATION

Company/HMO _____ Group # _____ ID # _____

Name of Primary Insurance Holder _____

AUTHORIZATION FOR TREATMENT

I (we) state that I am (we are) the parent(s)/guardian(s) having legal custody of the above child, and attest that the information above is complete and correct.

I authorize Haddonfield Child Care staff to administer emergency first aid to my child. I understand that in the case of accidental ingestion of poisonous materials, this may include treatment under the direction of the NJ Poison Control Center.

In the case of serious or life threatening situations, I (we) authorize the Haddonfield Child Care Executive Director or the Director's designee to request care of my child by local emergency personnel and to follow their recommendations regarding treatment and, if necessary authorize transport to the appropriate medical center.

I (we) hereby authorize emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

I understand that the following steps will be followed in a serious emergency:

- We will call for emergency first aid assistance/transportation.
- The parent/guardian will be called immediately.
- If we are unable to reach you directly, we will attempt to contact you through emergency persons listed on the child's information form.
- If we cannot contact you, we will do any or all of the following:
    - Attempt to notify the emergency person you have designated "*in loco parentis*"
    - Call the child's physician
    - Follow the recommendations of the child's physician and/or emergency response personnel regarding treatment and possible transport
    - Have the child transported to a hospital if necessary; a staff member will accompany the child if possible.

Signature of Parent/Guardian _____ Date _____