EDUCATIONAL SERVICE CENTER OF LAKE ERIE WEST

Early Childhood Emergency Medical Authorization

The purpose of the following form is to enable parents and/or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents and/or guardians cannot be reached.

Either Part I or Part II below must be completed. Do not complete both.

The form only authorizes the child care facility to secure emergency transportation for a child. This form does not authorize or guarantee treatment upon arrival at the designated source of emergency medical or dental treatment, as each emergency facility sets its own treatment procedures.

Part I. —Permission to Transport Child

I give the ESC of Lake Erie West my permission to transport my child, _____, to:

_____ for emergency medical care, to _____ for emergency dental care,
Hospital/Clinic *Dentist*
or to the nearest available source of assistance.

_____ _____
Parent's Signature *Date*

Part II. —Refusal to Grant Permission

I do not give the ESC of Lake Erie West my permission to transport my child,_____,

for emergency medical care or for emergency dental care. In the event of an illness or injury that requires emergency

medical or dental treatment, I wish the following action to be taken:_____

_____ _____
Parent's Signature *Date*

Early Childhood Program

Program Site _____

_____ Date of birth _____
Student's Name *(Last/First/Middle Initial)*

_____ Home Phone _____
Address *(Number/Street)*

_____ Email _____
(City/State/Zip)

Mother/Legal Guardian Name _____ Father/Legal Guardian Name _____

Mother cell phone: _____ Father cell phone: _____

Mother employed by _____ Father employed by _____

Work phone _____ Work phone _____

REQUIRED: ***The following people have permission to pick child up from school or be called in case of an emergency and parents cannot be reached:***

Name _____ Cell Phone _____

Name _____ Cell Phone _____

Preferred Doctor _____ Phone _____

Preferred Dentist _____ Phone _____

Preferred Hospital _____ Phone _____

Pertinent facts concerning child's medical history to which the school or doctor should be alerted:

Allergies: _____ Treatment, if any _____

Diabetic? ○ Yes ○ No Treatment _____

Other health concerns: _____

Medications: _____

Food Supplements or modified diet: _____