EMERGENCY TREATMENT CONSENT FORM

KIRK HOUSE PRESCHOOL
A MINISTRY OF MENLO CHURCH

Date: _____

As parent, agency representative or legal guardian, I here by give consent to Kirkhouse Preschool Saratoga to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S .) for (child's name) _____. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

☐ I understand that no guarantees have been made to me as to the effect of such treatment on my dependent's condition.

☐ I acknowledge responsibility for all reasonable charges in connection with transportation, care and treatment given during this period.

☐ I further authorize the school to have my dependent released into the custody of its representative, should hospital care no longer be required.

☐ I understand that the school will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

☐ The school will not assume responsibility for a child who has not been signed in upon arrival for class.

In the case of a medical emergency while my child is attending Kirk House Preschool, I understand that the following procedure will be followed:

☐ The school will contact parents/guardians or agency representative.

Mother can be reached at _____ or _____
Father can be reached at _____ or _____
Guardian can be reached at _____ or _____
Agency representative can be reached at _____

☐ If parent, guardian or agency representative is not available, the school will contact these emergency persons:
Name _____ Phone _____ Name _____ Phone _____
Name _____ Phone _____ Name _____ Phone _____

☐ The school will arrange for emergency transportation to the nearest emergency medical facility, if necessary. The dependent will be transported by an ambulance or other such vehicle when necessary.

☐ The school will contact dependent's physician or dentist .

Physician _____ Phone _____
Address _____
Dentist _____ Phone _____
Address _____
Dependent's allergies, if any: _____
Date of last tetanus booster _____
Medicines dependent is taking _____
Name of health insurance carrier _____
Group number _____
Name of dental insurance carrier _____
Group number _____
Signature of parent(s), guardian(s), or agency representative:
_____ Date _____
_____ Date _____
Home address _____