



Medical Alert Information (i.e., allergies, medical and/or handicapping conditions): \_\_\_\_\_

List any additional information which would be beneficial for the child care staff to know about your child: \_\_\_\_\_

Preferred Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

**NOTE: Immunization Record should accompany child.**

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**EMERGENCY CONTACT (OTHER THAN PARENTS):**

1. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

2. \_\_\_\_\_  
NAME RELATIONSHIP PHONE

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**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

If my child, \_\_\_\_\_, should become ill or  
CHILD'S FULL NAME

Injured at, \_\_\_\_\_, I understand that the  
NAME OF FACILITY

Facility will: (1) Contact me immediately and (2) Contact the person (s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

\_\_\_\_\_  
SIGNATURE RELATIONSHIP DATE

(OPTIONAL)

Sworn to and subscribed before me this \_\_\_\_\_, day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Florida – At Large.

My Commission Expires: \_\_\_\_\_

\_\_\_\_\_ who is/are personally known to me

\_\_\_\_\_ who has/have produced identification: \_\_\_\_\_