

EMERGENCY TREATMENT FORM

In presenting my son/daughter for diagnosis and treatment

Name: _____ for _____
 Mother Father Legal Guardian Son/Daughter
(Please provide first and last name)

Of _____ years of age; hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff of their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on said child's condition.

I have read this form and I certify that I understand its content.

We/I hereby give our/my consent to the Central Presbyterian Church Weekday Nursery School and Kindergarten who will be caring for our/my child _____
(First and last Name of Child)

for the period _____ to _____, to arrange for routine or emergency medical, surgical, dental care and treatment necessary to preserve the health of our/my child.

We/I acknowledge that we are/I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

| | |
|-------------------------|------------------------|
| Parents' Names: _____ | Pediatrician: _____ |
| Home Address: _____ | Dr. Phone #: _____ |
| Home Phone #: _____ | Surgeon: _____ |
| Cell Phone #: _____ | Surgeon Phone #: _____ |
| Dad Cell Phone #: _____ | Dentist: _____ |
| | Dentist Phone #: _____ |

Emergency contact other than parents in the event the parents cannot be reached.

Name: _____ Phone #: _____ Cell Phone #: _____

Father's Place of Business _____ Phone # _____

Business Address _____
(Street Address)

Business Address _____
(City, State, Zip)

Mother's Place of Business _____ Phone # _____

Business Address _____
(Street Address)

Business Address _____
(City, State, Zip)

Do You Have Health Insurance? YES

Name of Health Insurance Carrier: _____

Group No. _____

Agreement No. _____

Do You Have Health Insurance? NO

If NO, New Jersey Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call (800) 701-0710 or go online to <http://www.njfamilycare.org> to apply online.

Child's Allergies, if any: _____

Date of last tetanus booster: _____

Medicines Child is Taking: _____

Signature: _____
Mother, Father, or Legal Guardian (Date)