EMERGENCY TREATMENT FORM

In presenting my son/daughter for diagnosis and treatment

Name: _____ for _____

□ Parent □ 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 & 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.

Parent Name: _____ Cell Phone #: _____

Parent Name: _____ Cell Phone #: _____

Home Address: _____ Home Phone #: _____

Primary Email: _____ _____

Pediatrician Name: _____ Ped. Phone #: _____

Surgeon Name: _____ Surgeon Phone #: _____

Dentist Name: _____ Dentist Phone #: _____

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

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

(continued on reverse side)

Parent Place of Business _____ Phone # _____

Business Address _____
(Street Address)

Business Address _____
(City, State, Zip)

Parent 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: _____ _____
Parent or Legal Guardian (Date)

Revised: 08/2017