



Itsy Bitsy Early Learning Center

1275 15th Street - Fort Lee, NJ 07024

Phone: 201-224-4052 Fax: 201-224-9852

www.itsybitsyelc.com

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Child's Name: _____ DOB: _____

Address: _____

Parent(s) Name: _____

Parent(s) Address: _____

CHILD'S MEDICAL INFORMATION:

Medical Concerns: _____

Allergies: _____

Medicine(s) child is allergic to: _____

Name of Child's Doctor: _____

Telephone of Child's Doctor: _____

CHILD'S INSURANCE INFORMATION:

Company/HMO: _____

Group # _____ ID #: _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above names child and attest that the information is correct. I (we) authorize the Itsy Bitsy Early Learning Center director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnoses or treatment and hospital care to be rendered to the minor at a recognized facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be provided in the event of an emergency:

1. The Parent/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact the parent/guardian through all of the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all of the following:
 - (a) Call for Emergency first aid assistance/transportation.
 - (b) Call another physician.
 - (c) Have the child transported to an emergency hospital in the company of a staff member.

Parent Signature: _____

Date: _____

Director Signature: _____

Date: _____