Authorization for Medical Treatment

Name of Child: _____ Date of Birth: _____

Home Address/Postal Code: _____

Mother Name: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ Work Address: _____ Place of Work: _____

Father Name: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ Work Address: _____ Place of Work: _____

Alternate Name: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ Work Address: _____ Place of Work: _____

Authorization for Medical Treatment

Dr. Name: _____ Clinic Address: _____ Clinic Phone: _____

AHC #: _____ Immunizations Up To Date: Yes: _____ No: _____

Allergies/Special Medical Conditions/Regular Medication: _____

_____

Person Authorized to Pick Up Child: _____

_____

Emergency Medical Treatment: In the event of an emergency when I am not available, I authorize the administration of any medical procedures deemed necessary by my doctor, or, if unavailable, by any other physician selected by the Director/Designate of the Day Care Centre.

Parent Name: _____ Parent Signature: _____ Date: _____

Revised June 22. 2012