EDUCATIONAL SERVICE CENTER OF LAKE ERIE WEST

Early Childhood Emergency Medical Authorization

The purpose of the following form is to enable parents and/or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents and/or guardians cannot be reached.

Either Part I or Part II below must be completed. Do not complete both.

The form only authorizes the child care facility to secure emergency transportation for a child. This form does not authorize or guarantee treatment upon arrival at the designated source of emergency medical or dental treatment, as each emergency facility sets its own treatment procedures.

Part I. —Permission to Transport Child

I give the ESC of Lake Erie West my permission to transport my child, ______________________________, to:

____________________ for emergency medical care, to ____________________ for emergency dental care,
Hospital/Clinic *Dentist*
or to the nearest available source of assistance.

______________________________ ____________________
Parent's Signature *Date*

Part II. —Refusal to Grant Permission

I do not give the ESC of Lake Erie West my permission to transport my child,______________________________,

for emergency medical care or for emergency dental care. In the event of an illness or injury that requires emergency

medical or dental treatment, I wish the following action to be taken:______________________________

______________________________ ____________________
Parent's Signature *Date*

Early Childhood Program

Program Site ____________________

______________________________ Date of birth ____________________
Student's Name *(Last/First/Middle Initial)*

______________________________ Home Phone ____________________
Address
(Number/Street)

______________________________ Email ____________________
(City/State/Zip)

Mother/Legal Guardian Name ____________________ Father/Legal Guardian Name ____________________

Mother employed by ____________________ Father employed by ____________________

Work phone ____________________ Work phone ____________________

REQUIRED: ***The following people have permission to pick child up from school or be called in case of an emergency and parents cannot be reached:***

Name ____________________ Address ____________________ Phone ____________________
Name ____________________ Address ____________________ Phone ____________________
Preferred Doctor ____________________ Phone ____________________
Address ____________________
Preferred Dentist ____________________ Phone ____________________
Address ____________________
Preferred Hospital ____________________ Phone ____________________
Address ____________________

Pertinent facts concerning child's medical history to which the school or doctor should be alerted:

Allergies: ____________________ Treatment, if any ____________________
Diabetic? ○ Yes ○ No Treatment ____________________
Other health concerns: ____________________
Medications: ____________________
Food Supplements or modified diet: ____________________

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