AUTHORIZATION FOR MEDICAL TREATMENT
&
FIRST AID/CPR

Child's Legal Name:

Child's Date of Birth:

Address:

City:

Postal Code:

Phone Number:

Alternate Phone Number:

EMERGENCY CONTACTS

First Emergency Contact

Parent/Guardian: Name

Home Address:

City / Postal Code:

Phone Number:

Alternate Phone Number:

Second Emergency Contact

Name:

Relationship to child:

Home Address: Street / City / Postal Code

Phone Number:

Alternate Phone Number:

Third Emergency Contact

Name:

Relationship to child:

Home Address: Street / City / Postal Code

Phone Number:

Alternate Phone Number:

Doctor's Name:

Clinic Address:

Phone Number:

Immunization up to Date:

Yes No

Allergies / Special medication conditions / Regular medication:

Persons 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, by any other physician selected by the Director or Designated of the Ataan Head Start Program. I also authorize Opokaa'sin to provide or allow the provision of Health Care to my child, only upon written consent of the child's parent or the Health Care provided is in the nature of FIRST AID/CPR.

Signature: Parent/Guardian

Date: