CHILD CARE IN YOUR HOME (CCYH) FEE ASSISTANCE
CONSENT FOR EMERGENCY MEDICAL TREATMENT

(form must be completed per child)

I, _____, as the parent or legal guardian, do hereby give consent to my authorized CCYH provider, (Provider Name): _____, who will be caring for my child to obtain all emergency medical care prescribed by a duly licensed physician (M.D.) or Paramedic for:

_____ _____

Child's Full Name | Date of Birth

If the child listed above has any special needs, please list them here along with the appropriate physician to be contacted in an emergency:

_____

Child's Diagnosis and Special Needs *(if applicable)*

_____

Physician Name | Physician Phone | Hospital

Child's Allergies ***(if not applicable, please list n/a)***	Reaction

Child's Medication ***(if not applicable, please list n/a)***	Dosage	Frequency/Time

I have read this form and certify that I understand its contents. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of the child named above.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the child's condition.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

_____ _____

Parent/Guardian Signature *(I confirm the above information is still valid)* | Date

_____ _____

Parent/Guardian Signature *(I confirm the above information is still valid)* | Date (Year 2)

_____ _____

Parent/Guardian Signature *(I confirm the above information is still valid)* | Date (Year 3)