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Consent to Medical Treatment

In case of your child experiences a medical emergency while in Jane Boyd's care, we request all parents/guardians to complete the following *Consent to Medical Treatment* documentation below.

Should a medical emergency occur involving my child, Jane Boyd staff will make all attempts possible to reach me directly, and will seek emergency medical treatment for my child. In the event of an emergency, I (parent/guardian) _____ give Jane Boyd Community House permission to seek emergency medical treatment for my child (listed below). I understand that emergency medical treatment may require emergency medical technicians, services from an ambulance, and hospital visit/treatment, and I have provided my child's medical/insurance information below.

Child's Name: _____ **DOB:** _____

Current medications, allergies, or other medical needs the child has:

_____

_____

_____

Insurance Information (include company & policy #): _____

Child's Primary Care Physician (name, address, phone):

_____

_____

Child's Primary Dentist (name, address, phone):

_____

_____

Hospital Preference (Name, address, phone):

_____

_____

Parent/Guardian Signature: _____ Date: _____