Little Fishes Preschool

Medical Treatment Authorization and Consent

I, _____ [Full Legal Name of Parent/Guardian] hereby give consent as the [parent/legal guardian] of _____[Child's Full Name] for Little Fishes Preschool to provide medical care and treatment and emergency medical services associated with participation in Little Fishes Preschool and give my consent to Little Fishes Preschool and its representatives to obtain medical care from any licensed physician, hospital or clinic for the above-mentioned child for injury that could arise from activities in this program.
I further authorize release of any medical information necessary to provide treatment or to process a claim for accident/medical payment insurance for an injury or illness incurred while my child is participating as a member of the Little Fishes Preschool.

This authorization is for the time period when my child is in the care of **Little Fishes Preschool,** my child's **Preschool** and is effective **09/05/2017** until **06/30/2018**.

Child's Information
Child's Full Name: _____
Address: _____
Date of Birth: _____ Age: _____

Parent/Guardian's Information
Parent's/Guardian's Name 1: _____
Address: _____
Phone Number (H): _____ Phone Number (C): _____

Parent's/Guardian's Name 2: _____
Address: _____
Phone Number (H): _____ Phone Number (C): _____

Child's Health Information
Health Conditions (e.g. Asthma, Diabetes): _____
Allergies (e.g. to Medications, Food): _____
Prescription Medications: _____
Date of Last Tetanus Injection/Booster: _____

Child's Medical Care and Insurance Information

Physician/Pediatrician: _____ Phone Number: _____
Dentist/Orthodontist: _____ Phone Number: _____
Preferred Medical Facility: _____
Insurance Company: _____
Policy/Group Number: _____ Policy Holder: _____

SIGNATURE OF PARENT/GUARDIAN

Signature _____ Date _____

Print Name _____