Cinquegranelli Montessori

Every child comes here with his or her own gifts

CONSENT FOR EMERGENCY TREATMENT

Name of Child: ____ Date of Birth: _____________

Name of Parent(s)/Guardian(s): ____

CONSENT FOR EMERGENCY TREATMENT
Child's Primary Physician: _________________________________ Phone: ________________

Child's Dentist: ____ Phone: ________________

Preferred Hospital: _______________________________________ Phone: ________________

Date of Last Visit to Physician (must be within 2 years): ________________________________

Child's Known Allergies and Medical Conditions: _______________________________________

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Allergies require your child's primary health care provider to complete and sign a report of food allergies. All other medical conditions require your child's primary health care provider to complete a Health Care Plan or Child Asthma Plan as applicable. Parents must provide snack for their child if s/he has food allergies.

I hereby give permission for my child _________________________________ to be given emergency treatment by a qualified staff member of Cinquegranelli Montessori. I also give permission for my child to be transported by ambulance or aid care to Swedish Medical Center in Ballard (5300 Tallman Avenue NW, 206/782.2700).

In the event that I cannot be contacted, I further consent to the medical, surgical, hospital care treatment, and procedures to be performed on my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physicians to safeguard my child's health.

Parent/Guardian Signature: _______________________________________ Date: ___________

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