EFM RESPITE CARE
CONSENT FOR EMERGENCY MEDICAL TREATMENT

I, _____, as the parent or authorized representative, do hereby give consent to my authorized respite care provider(s) who will be caring for my child during respite child care hours to obtain all emergency medical care prescribed by a duly licensed physician (M.D.) or Paramedic for

_____ _____

Child's Name (form must be completed per child) Date of Birth

_____

Address City State Zip

Child's Medical Information

_____

Child's Health Insurance Carrier

_____

Physician Name Physician Phone Hospital

_____

Child's Diagnosis and Special Needs (if applicable)

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

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

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 Date