EFM RESPITE CARE
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 respite care provider(s) who will be caring for my child during respite care hours to obtain all emergency medical care prescribed by a duly licensed physician (M.D.) or Paramedic for:

_____ _____

Child's Full Name Date of Birth

_____

Physician Name Physician Phone Hospital

_____

Child's Diagnosis and Special Needs

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)