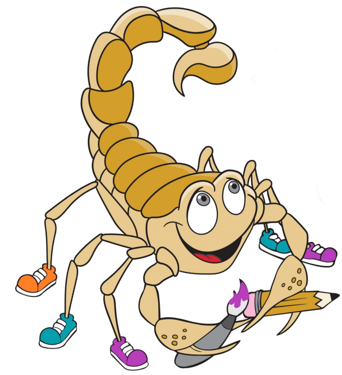
Early Childhood Education Center

NEVADA STATE COLLEGE



CONSENT FOR MEDICAL TREATMENT

Parent/Guardian agrees the provider may consult with the child's nurse or attending physician in regards to child's health as needed. In the event that we should have questions regarding the health of the enrolling child we may contact one, or more, of the following sources for information.

- ✓ Hospital of choice and phone number
- ✓ Local Health Entity

Child's Name: ________________________ Date of Birth: ________________________

Dr. Name:	Address:	Telephone:

In an emergency, I, ________________________, (Parent/Guardian), give my authorization to, __________________, (Provider's name) and any local physician, dentist or hospital to provide medical care and/or transport my child at my expense.

Medical Plan:	Policy #:	Telephone:

Does your child require additional accommodations? Explain:________________________
____

Are the problems serious enough to restrict our child's activities?
Explain:____

Describe, if any, special care required:_____________________________________

Does your child have frequent colds? Yes____ No__

List any allergies staff should be aware of:__________________________________

Is your child currently taking prescribed medication? Yes__ No__

Name of the medication?____

If yes, for what reason?____

______________________________________ ______________________

Signature of enrolling Parent/Guardian **Date**

Revised EW 12/2021