



NEVADA STATE UNIVERSITY
EARLY CHILDHOOD
EDUCATION CENTER



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 in 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, **Nevada State Early Childhood Education Center**, 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 your child's activities?

Explain: _____

Describe, if any, special care required: _____

Does your child have frequent colds? Yes No

Is your child currently taking prescribed medication? Yes No

Name of the medication? _____

If yes, for what reason? _____

Signature of enrolling Parent/Guardian

Date