STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Community Based Regulation Section

EMERGENCY MEDICAL CARE
Family Day Care Licensing

Attention Provider: ***This information must be kept current at all times.*** *Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable.*

Child's name:_____ Birthdate:_____

Parent's name:_____ Emergency Tel:_____

Parent's name:____ _____ Emergency Tel:_____

Address:_____ Town: _____Zip Code:_____

Allergies:_____ Last Tetanus_____

Medical Facility:_____ Phone #:_____

Insurance Carrier and_____

Insurance ID:_____

Physician to be called in an emergency:

Name:_____ Phone #:_____

Address:_____ Town_____ Zip Code:_____

I give my consent for the day care provider named_____, to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____. I will be responsible for all medical charges.

(hospital or walk-in clinic)

X_____
Signature

_____
Printed Name

_____
Date

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