CONSENT TO MEDICAL CARE AND TREATMENT OF A MINOR CHILD AND EMERGENCY MEDICAL INFORMATION

I hereby give permission that my child, _____, may be given emergency treatment by a qualified staff at the **Sandhurst Cooperative Preschool**. I further authorize an consent to medical, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physician, hospital, or aid car attendance when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health, and I cannot be contacted. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.
"I certify (or declare) under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct"

_____ _____
Signature Address

_____ _____
Phone Number Date

Child's Name: _____ Birthdate: _____

Regular medications: _____

Allergies and drug reactions: _____

Date of last tetanus shot: _____

Child's Physician: _____ Physician's Phone: _____

Other health information: _____

Parent's contact number: _____ Other number: _____

Parent's work phone: _____ Other number: _____

Emergency contact: _____ Phone: _____

Insurance coverage: _____ Membership number: _____

Employer: _____ Group number: _____

MEDICAL EMERGENCY RESPONSE PLAN

Photo of child

Child's Name: _____

Date of Birth: _____

Allergy/Intolerance to: _____
_____

Asthma? Yes* □ No □ * High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION:

Systems:	Symptoms:
MOUTH	itching & swelling of the lips, tongue or mouth
THROAT	itching and/or a sense of tightness in the throat hoarseness and hacking cough
SKIN	hives, itchy rash, and/or swelling about the face or extremities
GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	shortness of breath, repetitive coughing, and/or wheezing
HEART	'thready' pulse, 'passing-out'

Action for MINOR reaction:

If symptom(s) are: _____

□ Administer: _____

□ Then call parent/guardian: _____ alt phone: _____

□ If condition does not improve **within 10 minutes**, follow steps for Severe reaction below:

Action for SEVERE reaction:

If symptom(s) are: _____

□ Administer: _____ IMMEDIATELY!
□ Call: 911 (never hesitate to call 911)
□ Call: Parent/guardian□ Call: Health care provider

Medical Condition other than allergy: _____

Attach Physician's Protocol and/or Physician's Orders for Medication at School

Parent/guardian name: _____

Parent/Guardian signature: _____ Date: _____