*Christina Kent Early Childhood Center*

# *Medical Information and Release*

______________________________________________ ______________________
Child's Name Date of Birth

____________________________________________________________________________
Hospital / Clinic Preference

__________________________________________ ____________________
Physician's Name Phone Number

__________________________________________ ____________________
Insurance Company Policy Number

__________________________________________ ____________________
Dentist's Name Phone Number

Allergies / Special Health Considerations: ___________________________________

___________________________________________________________________________

I certify that my child is enrolled at Christina Kent Early Childhood Center (CKECC) and is therefore in the care and custody of the staff of that facility during the weekdays. In the event my child becomes ill, is injured, or is deemed contagious and the parent/emergency contact person cannot be reached, I give my permission to the staff of CKECC to have my child transported to the doctor or hospital by a paramedic or ambulance. In addition, I give my consent to the physician, medical center and its staff to treat my child. _____ Yes

_____________________________________________ ____________________
Parent / Guardian Signature Date

# Health Information Authorization

Names of individuals authorized by the family to have access to health information about the child.

1. ______________________________ Phone Number _________________
2. ______________________________ Phone Number _________________

No, I do not authorize anyone to access my child's health information.

Parent Signature: _______________________________________

Yes, I authorize the person(s) stated above to have access to my child's health

Parent Signature: _______________________________________