SPRING VALLEY BAPTIST PRESCHOOL

Consent to Medical Treatment for Minor

(please complete for each child enrolled)

I hereby authorize any duly authorized physician, emergency medical technician, nurse, hospital, or other medical facility or medical provider to treat said minor for the purpose of attempting to treat or relieve any injuries received by said minor while he/she was a participant or observer of any activity at SVBC Preschool. I authorize any licensed physician or licensed medical provider to perform any procedure which he/she deems advisable in attempting to treat or relieve any injuries, health emergency, or any related unhealthy conditions of said minor that he/she may encounter while in attendance at SVBC Preschool. I consent to the administration of anesthesia as deemed advisable by any licensed physician or licensed medical provider. I realize and appreciate that there is a possibility of complications and unforeseen consequences in any medical treatment, and I assume any such risk on the behalf of myself and said minor. I acknowledge that no warranty is being made as to the results of any treatment.

MINOR'S NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

Do the staff and volunteers of SVBC Preschool have permission to take emergency procedures that they deem necessary in the event your child is hurt or experiences a health crisis?

YES NO (Please circle your selection) _____ Please initial

Do the staff and volunteers of SVBC Preschool have permission to call emergency personnel if they deem it necessary?

YES NO (Please circle your selection) _____ Please initial

Do the staff and volunteers of SVBC Preschool have permission to transport your child in a personal vehicle if they deem it necessary for purposes of medical treatment or intervention?

YES NO (Please circle your selection) _____ Please initial

Current Medications Taken: _____

_____

Drug Allergies: _____

Environmental Allergies: _____

Food Allergies: _____

Medical Problems: _____

_____

Physical Limitations: _____

_____

Hearing Limitations: _____

Vision Limitations: _____

Pediatrician: _____

Pediatrician Practice Name: _____

Practice Phone Number: _____

If your child needs to be transported by ambulance for medical treatment or attention, what is your preferred hospital for treatment?