

**St. Paul UMC Preschool**

**Parental Consent for Emergency Medical Treatment**

In case of emergency, I (we), in the event of my (our) unavailability, hereby authorize the faculty and staff of St. Paul UMC Preschool to grant permission for any medical or surgical treatment by the medical staff at Sentara Northern Virginia Medical Center, or by the physician, if any, designated at the bottom of this form, on behalf of my (our) child.

Child's Name: \_\_\_\_\_

Parent(s) or emergency contact individual, designated on the Student Information form, will be notified if the child becomes ill at school. Parents will then come to school or have the emergency contact individual come to school to collect the sick child. The teacher, or director can administer no medications, unless a doctor and the parent provide written permission and directions prior to administration of the medication.

\_\_\_\_\_  
Parental Signature                      Print Name                      Day Phone                      Cell Phone

\_\_\_\_\_  
Parental Signature                      Print Name                      Day Phone                      Cell Phone

Known Allergies: \_\_\_\_\_

Known Illnesses: \_\_\_\_\_

Daily Medications: \_\_\_\_\_

Date of last DtaP shot \_\_\_\_\_

Pediatrician Name: \_\_\_\_\_

Pediatrician Telephone Number: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Policy/Contract #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber's Employer (if insurance is thru a business): \_\_\_\_\_