Emergency Medical Treatment Authorization

Child's Doctor: Name: _____ Phone: _____

Address: _____

Hospital Preference: _____
(Required information)

Health Insurance Information: Name of Insured: _____

Policy Carrier: _____

Policy #: _____

If your child becomes ill and is unable to attend school, what "sick child" arrangements have you made?

_____

Is you child up to date on their immunizations? ***Yes / No***

Date of last DtaP Immunization: _____

As a parent or legal guardian of: _____
(Name) *(Birth date)*

I hereby authorize Lane Community College Child and Family Center, 4000 E. 30th Avenue, Eugene, OR 97405, telephone 463-5519, to consent to any medical or surgical treatment of the above named child which medical personnel deems advisable, if a parent or legal guardian can not be reasonably located when the child is brought for treatment. In an emergency, the Child and Family Center reserves the right to call an ambulance and any available physician at the parent's expense.

Please check appropriate boxes below:

Do you give permission to the Child and Family Center to have your child's picture taken or voice recorded for news or publicity purposes? ***Yes / No***

The Child and Family Center staff will administer medication to children that is prescribed by a doctor. Prescription medication must be in the original bottle, have the child's name, dosage, and a current date on it. Instructions for administration must be given on a daily basis on a form available from a staff member. Do you give permission for the Child and Family Center staff to give prescribed medication as described above? ***Yes / No***

Signature _____ Date _____