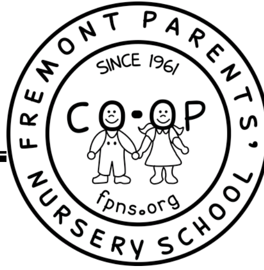

Centerville Campus
4200 Alder Ave
Fremont, CA 94536
(510) 793-8531

Consent for Emergency Medical Treatment
And Pick Up Authorization/Disaster Release Form

Child's Name ____________________________________M/F ______ Home Phone ____________________
Address__________________________________ City ____________Zip____________ Birth Date __________

	Name	Employed By	Phone/Pager/Cell	Hours
Mother				
Father				
Guardian				

IF I DO NOT PICK UP MY CHILD FROM FPNS AT THE END OF THE SCHOOL DAY OR IN THE EVENT OF AN EMERGENCY SITUATION, I AUTHORIZE MY CHILD TO BE RELEASED TO ANY OF THE FOLLOWING PEOPLE. Persons picking up a child not familiar to the teacher will need to present picture identification before the child is released to them. Please add to or change this list as needed throughout the year.

	NAME	PHONE	ADDRESS	RELATIONSHIP
1.				
2.				
3.				
4.				
5.				

Your Child's Dr. ____________________________________ Dr's Number ________________________
Address ____ City ________________________
Insurance Company ___________________________________ Policy/Group/Card Number ______________
Action to be taken if Physician cannot be reached? ____

-CONSENT FOR EMERGENCY MEDICAL TREATMENT-

As the parent or authorized representative, I hereby give consent to Fremont Parents' Nursery School to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D.) osteopath (D.O.) or dentist (D.D.S.) for ______________________________. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the child named above.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

Signature ____ Date ____________
Mother Father

SCHOOL USE ONLY

Date ____________________ Time____________________

Signature of person child was released to ______________________ Phone ______________________