



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? _____

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-CONSENT FOR EMERGENCY MEDICAL TREATMENT-
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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

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SCHOOL USE ONLY
.....

Date _____ Time _____

Signature of person child was released to Phone _____