



Pleasant Hill Nursery School
Medical Treatment

Permission for Medical Treatment

Child's Full Name: _____ Date of Birth: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Medical Considerations

911 WILL BE CALLED. PARENTS WILL BE NOTIFIED.

Child's Doctor: _____ Phone: _____

Insurance Carrier #: _____ Insurance ID #: _____

Allergies: _____

Medical Considerations: _____

Authorization

An attempt will be made to contact the student's parent, guardian or next of kin, whenever possible, prior to a decision regarding any major treatment (medical, surgical, dental, etc.). However, in the event of an emergency or if the parent or guardian cannot be contacted, Pleasant Hill Nursery School has the authority to seek and obtain medical treatment as needed at the cost and expense of the student or his or her family.

I give permission to Pleasant Hill Nursery School to authorize emergency medical treatment for my child _____ in my absence.

Signature of Parent or Guardian

Date