Emergency Medical Consent

This form grants medical care in parental absence. This form must be presented upon admission for treatment.

Child's Full Legal Name____

In the event that your child may require emergency or surgical care while attending Angeli Cristiani Childcare 2200 Beaver Ave Des Moines Iowa 50310. Every effort will be made to notify the parent/guardians first. However in the event you are out of the city or unable to be reached the center requires the following information to be provided.

In the event my child ____

Requires emergency/surgical care, I hereby give my consent for medical treatment to

Hospital ____

DR. ____

His/her designee to provide this care I agree to pay all the costs and fees contingent on any emergency medical care or treatment for my child as secured or authorized under this consent.

Name of Parent/Legal Guardian ____

Address ____

Home Phone ____________________Work Phone____________________Cell Phone____________________

Doctor_______________________________________Dr. Phone ___________________________________

Doctor Address ____

Hospital Preference ____

Emergency Contacts ____________________________________Relationship __________________________

Home Phone ____________________Work Phone____________________Cell Phone____________________

Date of last Tetanus_____________________________Religious Preference_____________________________

Insurance #_______________________________________Name____

Fathers Signature ________________Date__________________________Social security #__________________

Mothers Signature________________Date__________________________Social Security #__________________

This consent will be in effect beginning Date ____________________