CONSENT FOR EMERGENCY MEDICAL TREATMENT-Child Care Centers Or Family Child Care Homes

	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO
	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:
	DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE
HOME ADI	DRESS
HOME PHO	ONE WORK PHONE
(//////////////////////////////////////
	- CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICE
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