DPHHS-QAD/CCL-113
(Revision 7-2006)

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: _____ **Birth Date:** _____

Address: _____

Mother / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Father / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Physician / Medical Care Source: _____ **Contact Number:** _____

Health Insurance Carrier & Policy Number: _____

Persons authorized to pick up child:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

– SEE REVERSE SIDE –

WRITTEN CONSENT IS GIVEN FOR:

☐ **Yes** ☐ **No** EMERGENCY MEDICAL CARE

☐ ADMINISTRATION OF PRESCRIPTION MEDICATIONS **Medication Authorization form and Medication Administration Log Must be completed**

☐ ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS **OTC Medication Authorization Form and Medication Administration Log must be completed**

☐ ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:
Please Specify:

☐ TRIPS: ☐ **Yes** ☐ **No** TRANSPORTATION BY THE FACILITY FOR TRIPS

☐ **Yes** ☐ **No** DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

HEALTH HISTORY

	YES	NO		YES	NO
Hay fever, asthma, or wheezing	☐	☐	Chickenpox	☐	☐
Eczema or frequent skin rashes	☐	☐	Diabetes	☐	☐
Convulsions/Seizures	☐	☐	Trouble with passing urine / bowel movement	☐	☐
Heart condition	☐	☐	Frequent colds, sore throats, earaches, tonsillitis, pneumonia	☐	☐

	YES	NO
Allergies or reaction: (food or other)	☐	☐

Please Explain:

	YES	NO
Other Health Concerns (special disabilities):	☐	☐

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN **DATE**