# CONSENT FOR EMERGENCY MEDICAL TREATMENT-

Child Care

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

UCSB Children's Centers TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER WHATEVER
CHILD'S NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

| INSURANCE CARRIER | POLICY NAME HOLDER | POLICY NUMBER |
|---|---|---|
| | | |

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE _____ DATE _____

Home Address: _____

_____

Home Phone: (  ) _____ Work Phone: (  ) _____