

CTK Emergency Consent Form

Child's Full Name: _____ Home Phone: _____

Address: _____

Mother (or guardian) Name: _____

Cell Phone: _____ Work Phone: _____

Father (or guardian) Name: _____

Cell Phone: _____ Work Phone: _____

Doctor/Pediatrician _____ Phone: _____

Preferred Hospital: _____

Person (other than parent/guardian) authorized to make emergency care decisions:

1. Name: _____

Cell Phone: _____ Home Phone: _____

2. Name: _____

Cell Phone: _____ Home Phone: _____

With my signature I authorize Plan #1: If the child has an accident that produces a minor injury such a small bump, bruise or cut that obviously does not require stitches, staff members will take appropriate action such as comforting the child, washing the wound, applying ice or a band-aid. *According to the Florida Department of Children and Families, staff members are not allowed to administer any kind of medicinal materials to a wound. _____ YES _____ NO

With my signature I authorize Plan #2: If the child has an accident that produces an injury that calls for professional medical care, but not emergency care, the parent, guardian or designated emergency contact person will be called immediately. Examples of such situations would be: cuts that require stitches, excessive bleeding of any kind, large bumps or bruises or possible fractures. _____ YES _____ NO

With my signature I authorize Plan #3: In the case of an obvious emergency situation, Emergency Medical Services (911) would be called immediately. The parent, guardian or designated emergency contact person would then be notified. All informed persons would then meet at the hospital or emergency center. Preferred hospitals may be requested however Emergency Medical Services will make the final decision. _____ YES _____ NO

Signature of applicant: _____

(must be signed in front of a notary)

Sworn and subscribed before me

this _____ day of _____ 20_____.

Notary: _____

Personally Known ____ Produced Identification: ____

Type: _____