

PARENTAL EMERGENCY MEDICAL & DENTAL CONSENT



PICK-UP PERMISSION FORM

Child's Name _____ Date of Birth _____

In the event that my child may require emergency medical, dental, and/or surgical care while I am out of the city or unable to be reached;

I hereby give my consent to medical, dental, and/or surgical treatments to the (hospital) Mercy Medical North Iowa and doctor (name) _____, dentist (name) Dr. Lala or his/her designee to provide this care. I agree to pay all the costs and fees contingent on any emergency medical, dental, and/or treatment for my child as secured or authorized under this consent.

Parents/Legal Guardian/Authorized Pick-Up

Sign-in passcode (6-digits) _____

Parent Name _____

Parent Name _____

Email _____

Email _____

Address _____

Address _____

Home Phone _____

Home Phone _____

Work Place _____ Phone _____

Work Place _____ Phone _____

Cell Phone _____

Cell Phone _____

Child's Doctor _____ Ph. _____

Child's Dentist Dr. Lala Ph. 641-423-4225

Address _____

Address 23 North Federal Mason City Iowa 50401

Hospital Preference Mercy Medical North Iowa

Please list any registered sex offender(s) associated with your family that may need access to the centers _____ Offenders tier status _____ (Tier 3 offenders are not permitted on Charlie Brown property, all others require written permission).

Person(s) to be contacted in emergency if parents are unavailable and are AUTHORIZED TO PICK UP CHILD.

NAME HOME PHONE WORK PHONE RELATIONSHIP

Are there any custody or restraining orders for person(s) who may attempt to pick-up or have contact with the child while at the center?

Name _____

Medical Information

Medical History _____ On-going Medication _____

Know Allergies _____

Date of last Vision _____ Dental Exam _____ Hearing Screening _____

Insurance Company _____ Policy holder's ID _____

I give permission to take my child's temperature if he/she appears to be ill.

Signature Parent/Guardian _____ Date _____

Signature Parent/Guardian _____ Date _____

Washington
700 N. Washington
Mason City
641-423-6029

Lake Town
7 B S 8th
Clear Lake
641-357-7277

West Town
600 1st NW #108
Mason City
641-424-0065

STAFF EMERGENCY MEDICAL & DENTAL CONSENT

Staff's Name _____ Date of Birth _____

Social Security # _____

Address _____

Home Phone _____

Work Phone _____

Cell Phone _____

In the event that I may require emergency medical, dental, and/or surgical care while I am working at Charlie Brown Preschool and Child Care, I hereby give my consent to medical, dental, and/or surgical treatments to the (hospital) _____ and doctor (name) _____, dentist (name) _____.

Staff's Doctor _____ **Staff's Dentist** _____

Address _____ Address _____

Phone _____ Phone _____

Hospital Preference _____

Person(s) to be contacted in case of emergency.

NAME	HOME PHONE	WORK PHONE	RELATIONSHIP
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Information

Medical History _____

On Going Medications _____

Known Allergies _____

Insurance Company _____ Policy holder's ID _____

Staff Signature _____ Date _____



Washington

Lake Town

West Town

CACFP