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

Email: Age: School: Grade: Allergies:

## EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.					
	Birth Date:				
	Home Number:				
Address:	Cell Number:				
	Work Number:				
	Home Number:				
Address:	Cell Number:				
	Work Number:				
	Contact Number:				
	Contact Number:				
Physician / Medical Care Source:	Contact Number:				
Persons authorized to pick up child:					
Name:	Name:				
Nama	Nama				

## **WRITTEN CONSENT IS GIVEN FOR:**

☐ Yes ☐ No EMERGENCY MEDICAL CAR	RE							
ADMINISTRATION OF PRESCRIPTION MEDICATIONS		Medication Authorization form and Medication Administration Log  Must be completed						
☐ ADMINISTRATION OF NON-PRESCRIPTION	MEDICATI	ONS	OTC Medication Authorization Form and Medication Administration  Log must be completed					
ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS: Please Specify:								
□ TRIPS: □ Yes □ No	NSPORT	A' THE	FACILITY FOR TRIPS		I SICKNESS,			
			OVIDED BY THE FACILITY (Facility Has the Option to Offer	r)				
☐ Yes ☐ No  THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E.  IF YOUR CHILD IS TRANSPORTED BY THE FACILI SEIZURES, ETC.) DURING TRANSPORTATION?								
		Н	EALTH HISTORY					
	YES	NO	<del></del>	<u>YES</u>	<u>NO</u>			
Hay fever, asthma, or wheezing			Chickenpox					
Eczema or frequent skin rashes			Diabetes					
Eczema of frequent skirrasties			Trouble with passing urine / bowel					
Convulsions/Seizures			movement					
Heart condition			Frequent colds, sore throats, earaches, tonsillitis, pneumonia					
	YES	NO						

Allergies or reaction: (food or other) Please Explain:				
Other Health Concerns (special disabilities): □ □	YES	<u>NO</u>	Please Explain:	
SIGNATURE OF PARENT OR GUARDIAN				DATE