



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Community Based Regulation Section

EMERGENCY MEDICAL CARE Family Day Care Licensing

Attention Provider: Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable.

Child's name: _____ Birthdate: _____

Parent's name: _____ Emergency Tel: _____

Parent's name: _____ Emergency Tel: _____

Address: _____ Town _____

Allergies: _____ Last Tetanus _____

Medical Facility: _____ Tel: _____

Insurance Carrier and _____

Insurance ID: _____

Physician to be called in an emergency:

Name: _____ Tel: _____

Address: _____ Town _____

I give my consent for the day care provider named _____, to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____ . I will be responsible for all medical charges. *(hospital or walk -in clinic)*

X _____
Signature

Printed Name

Date (Valid one year only.)

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