Y.M. & Y.W.H.A. of Williamsburg, Inc.

PARENT CONSENT FOR EMERGENCY MEDICAL TREATMENT/AUTHORIZATION

Child's Name:	**Classroom/Teacher:**

In the event I cannot be contacted I hereby give consent for emergency medical treatment of the child listed above, while under the care of Head Start Staff.

This Emergency Medical care may include **physician examination** and any **necessary tests** which, in the opinion of the attending physician are deemed **necessary or advisable.**

This **does not** include the right to perform surgical operations without my further consent, except in the case of emergency and **advised** by physician to be vital to my child's recovery, and after every effort has been made to locate me, I am found to be unavailable.

GENERAL INFORMATION	
Child Medicaid Number:	**Child's Date of Birth:**
Doctor/Clinic:	**Address:**
Doctor to be contacted:	**Telephone Number:**

PARENT/LEGAL GUARDIAN INFORMATION	
Parent/legal guardian:	**Telephone number:**
Address:	
Company Name:	**Telephone Number:**
Company Address:	

MEDICAL H.M.O. INFORMATION	
Name of H.M.O.	**Approval Telephone**
Name of Doctor:	**Doctor's Telephone:**

HEALTH INSURANCE INFORMATION	
Child's Health Insurance if no Medicaid or Medicaid H.M.O.:	
Name of Health Insurance:	**Identification#**

Parent/Legal Guardian Signature **Date** **Witnessed By (Head Start Staff)**

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