

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

**PARENT CONSENT FOR EMERGENCY MEDICAL  
TREATMENT/AUTHORIZATION**

<b>Child's Name:</b>	<b>Classroom/Teacher:</b>
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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**

<b>Child Medicaid Number:</b>	<b>Child's Date of Birth:</b>
<b>Doctor/Clinic:</b>	<b>Address:</b>
<b>Doctor to be contacted:</b>	<b>Telephone Number:</b>

**PARENT/LEGAL GUARDIAN INFORMATION**

<b>Parent/legal guardian:</b>	<b>Telephone number:</b>
<b>Address:</b>	
<b>Company Name:</b>	<b>Telephone Number:</b>
<b>Company Address:</b>	

**MEDICAL H.M.O. INFORMATION**

<b>Name of H.M.O.</b>	<b>Approval Telephone</b>
<b>Name of Doctor:</b>	<b>Doctor's Telephone:</b>

**HEALTH INSURANCE INFORMATION**

<b>Child's Health Insurance if no Medicaid or Medicaid H.M.O.:</b>	
<b>Name of Health Insurance:</b>	<b>Identification#</b>

Parent/Legal Guardian Signature

Date

Witnessed By (Head Start Staff)