

# CHILD'S MEDICAL INFORMATION AND PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

## CHILD'S FAMILY INFORMATION

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ School \_\_\_\_\_  
Address \_\_\_\_\_

Name of Custodial Parent(s) or Legal Guardian (s) \_\_\_\_\_

Address \_\_\_\_\_

Telephone #s Home \_\_\_\_\_ Parent #1 (Name) \_\_\_\_\_

Work \_\_\_\_\_ Cell \_\_\_\_\_

Parent #2 (Name) \_\_\_\_\_

Work \_\_\_\_\_ Cell \_\_\_\_\_

## CHILD'S MEDICAL INFORMATION

General Allergies \_\_\_\_\_

Allergies to Medication(s) \_\_\_\_\_

Other Medical Problems, Conditions or Special Needs \_\_\_\_\_

Are any of the allergies or condition(s) described above serious, chronic, or life threatening, or will they require any special care during program hours? \_\_\_ yes \_\_\_ no

If yes, please elaborate\* \_\_\_\_\_

\*Please note: This may require the completion of a Special Health Care Needs Plan by your medical provider. Children with chronic or life-threatening allergies or other medical conditions which may require administration of medication, special training of staff, or other special care by HCC, must have a special care plan completed by a health care provider before participating in the program. This may delay entrance into the program, so please plan accordingly.

## CHILD'S PHYSICIAN INFORMATION

Child's Primary Medical Provider \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Other Medical Provider (if relevant) \_\_\_\_\_ Phone \_\_\_\_\_

*CHILD'S INSURANCE INFORMATION*

Company/HMO \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Name of Primary Insurance Holder \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

Re: (name of child): \_\_\_\_\_

I (we) state that I am (we are) the parent(s)/guardian(s) having legal custody of the above child, and attest that the information above is complete and correct.

I agree to have a Special Care Plan completed by a physician if deemed necessary by Comet Care, and to assist in securing any special training, or wait for admission until such training can be secured, if such training is required by the staff to accommodate my child's special needs.

I authorize Comet Care staff to administer emergency first aid to my child. I understand that in the case of accidental ingestion of poisonous materials, this may include treatment under the direction of the NJ Poison Control Center.

In the case of serious or life threatening situations, I (we) authorize the Comet Care Executive Director or the Director's designee to request care of my child by local emergency personnel and to follow their recommendations regarding treatment and, if necessary authorize transport to the appropriate medical center.

I (we) hereby authorize emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

I understand that the following steps will be followed in a serious emergency:

- We will call for emergency first aid assistance/transportation.
- The parent/guardian will be called immediately.
- If we are unable to reach you directly, we will attempt to contact you through emergency persons listed on the child's information form.
- If we cannot contact you, we will do any or all of the following:
  - o Attempt to notify the emergency person you have designated "in loco parentis"
  - o Call the child's physician
  - o Follow the recommendations of the child's physician and/or emergency response personnel regarding treatment and possible transport
  - o Have the child transported to a hospital if necessary. A staff member will accompany the child if possible.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_