CONSENT FOR EMERGENCY MEDICAL TREATMENT-Child Care Centers Or Family Child Care Homes

DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE HOME ADDRESS		
PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR THIS CARE MAY BE GIVEN UNDER NAME WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE. CHILD HAS THE FOLLOWING MEDICATION ALLERGIES: DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I	HEREBY GIVE CONSENT TO
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