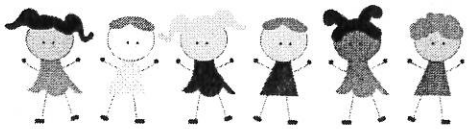

LITTLE BLESSINGS
PARENTS' DAY OUT
A Ministry of First United Methodist Church of Castle Rock

EMERGENCY MEDICAL AUTHORIZATION

I, _____ parent/guardian of _____, date of birth being_____, do hereby give permission to Little Blessings PDO, Family Childcare Provider, to secure and authorize such emergency medical care and/or treatment as above-named child might require while under the supervision of said Childcare Provider. I further authorize said childcare provider to administer emergency care/treatment as required, until medical assistance is available. I also agree to pay all costs and fees contingent of any emergency medical care and/or treatment for said child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it will be necessary to have the following information:

Child's Full Name_____

Child's Address_____

Home Phone Number_____

Mother's Work Phone Number_____

Father's Work Phone Number_____

Any known allergies or medical conditions of child: _____

Medical Insurance Information

Name of Company_____

Name of Member_____

Policy Number_____

Group Number_____

Phone Number_____

Signature of Mother_____ Date _____

Signature of Father_____ Date _____