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

	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO
	TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
	PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR
	THIS CARE MAY BE GIVEN UNDER 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
HOME AD	DRESS
HOME PH	ONE WORK PHONE
() ()
	01) (CONFIDENTIAL)
CON	CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ISENT FOR EMERGENCY MEDICAL TREATMENT- <u>d Care Centers Or Family Child Care Homes</u> AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO
CON	ISENT FOR EMERGENCY MEDICAL TREATMENT- d Care Centers Or Family Child Care Homes AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO
CON	ISENT FOR EMERGENCY MEDICAL TREATMENT- d Care Centers Or Family Child Care Homes
CON	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR THIS CARE MAY BE GIVEN UNDER WHATEVER
CON	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO FACILITY NAME PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR
CON Chil	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR NAME CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED
CON Chil	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO FACILITY NAME PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR NAME CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.
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CON Chil	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO ACCOUNTIONS ARE AUTHORIZED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR ADDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE. HAS THE FOLLOWING MEDICATION ALLERGIES: DATE DATE DATE
Chil CHILD	AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO