STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Community Based Regulation Section

EMERGENCY MEDICAL CARE
Family Day Care Licensing

Attention Provider: ***This information must be kept current at all times.*** *Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable.*

Child's name:____ Birthdate:___________________

Parent's name:____ Emergency Tel:_____________

Parent's name:____ Emergency Tel:_____________

Address:______________________________ Town: ______________________Zip Code:________

Allergies:____ Last Tetanus________________

Medical Facility:____ Phone #:_______________________

Insurance Carrier and____

Insurance ID:____

Physician to be called in an emergency:

Name:____ Phone #:_______________________

Address:_________________________________ Town________________ Zip Code:_______

I give my consent for the day care provider named____, to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____________________________________. I will be responsible for all medical charges.

(hospital or walk-in clinic)

X____

Signature

____

Printed Name

____

Date

S:\Division\Licensure\Family\FieldForms\F_EmergMedCare.doc 3/16/12

Phone: (860) 509-8045, Fax: (860) 509-7541
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12CBR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer