

State of Montana  
Department of Public Health and Human Services  
Quality Assurance Division – Licensure Bureau  
Child Care Licensing

## EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Mother / Legal Guardian's Name: \_\_\_\_\_ Home Number: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Number: \_\_\_\_\_

Father / Legal Guardian's Name: \_\_\_\_\_ Home Number: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Work Address: \_\_\_\_\_ Work Number: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Physician / Medical Care Source: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Health Insurance Carrier & Policy Number: \_\_\_\_\_

Persons authorized to pick up child:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

**WRITTEN CONSENT IS GIVEN FOR:**

**Yes**  **No** EMERGENCY MEDICAL CARE

ADMINISTRATION OF PRESCRIPTION MEDICATIONS

**Medication Authorization form and Medication Administration Log  
Must be completed**

ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS

**OTC Medication Authorization Form and Medication Administration  
Log must be completed**

ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:

Please Specify:

**TRIPS:**  **Yes**  **No** TRANSPORTATION BY THE FACILITY FOR TRIPS

**Yes**  **No** DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

**HEALTH HISTORY**

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Hay fever, asthma, or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>
Eczema or frequent skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with passing urine / bowel movement	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds, sore throats, earaches, tonsillitis, pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

**Allergies or reaction: (food or other)**  YES  NO

Please Explain:

**Other Health Concerns (special disabilities):**  YES  NO

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN

DATE