3500 Sunrise Highway | Suite 101 | Great River, NY 11739 | www.TinyTreasuresEI.com
Phone: 631-650-0564 | Email: Jen@TinyTreasuresEI.com

Emergency Medical Release Form

Child's Name: _____ DOB _____

If the child requires medical care, the following procedures will be followed:

- You will be called immediately
- If I cannot reach you, the child's family doctor will be called at:

Child's Doctor: _____

Address: _____

Phone #: _____

- If the doctor is not available, the child will be taken to the nearest hospital emergency room for treatment.

Health Insurance Carrier: _____

Insured Name: _____

Policy Number: _____

I hereby give my consent to any approved staff member of *Tiny Treasures Child Care* to authorize medical, surgical, and/or dental treatment including hospitalization for my child(ren) while they are in child care.

Name of Child: _____

Name of Child: _____

Name of Child: _____

Name of Parent: _____ Relationship to child: _____

Parent Signature: _____ Date: _____