LEARNING LAMB EARLY DEVELOPMENT CENTER

CONSENT FOR TREATMENT

This is to certify that for the period from: _____ TO_____

(DATE) (DATE)

I hereby contribute and appoint

_____ (FULL NAME OF CENTER)

my true and lawful attorney, for the purpose of authorizing medical treatment to, and the performance of any procedure determined to be necessary after consultation with the emergency or Family Physician on my child(ren) in the event of an emergency situation where neither parent nor designated emergency contacts can be reached:

| Child's Name | Birthdate | Allergies/Problems | Last Tetanus |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Family Physician: Office Number:

Address:

Signed:

Relationship to Child(ren):
(Mother/Father/Legal Guardian)

Witnessed By:

Witnessed By:

THIS FORM MUST BE SIGNED BY (TWO) WITNESSES