**CHC LEARNING CENTER**

**A Program Of The Center For Handicapped Children, Inc.**

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# EMERGENCY CARE CONSENT FORM

## July 1, 2024 - June 30, 2025

*To be completed by parent, legal guardian, or authorized primary caregiver*

| Student Name: | DOB: |
|---|---|
| Address: | Home Phone: |
| Who does student live with or reside at? | |
| Mother's Name: | Father's Name: |
| Address:<br>(If different from student) | Address:<br>(If different from student) |
| Home Phone:<br>(If different from student) | Home Phone:<br>(If different from student) |
| Work Phone: | Work Phone: |
| Cell Phone: | Cell Phone: |
| E-Mail Address:<br>(Please fill in so we can include address in the e-mail directory) | E-Mail Address: |

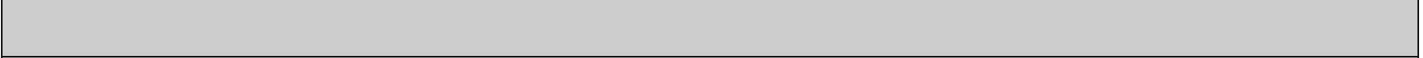
**In the case of an emergency, if I as a parent, legal guardian, or authorized primary caregiver cannot be reached; I authorize CHC to contact and release my child to either of the two individuals listed below.**

| ______________________ | ______________________ | ______________________ | __________ |
|---|---|---|---|
| ***Your name – please print*** | ***Your signature*** | ***Your relationship to child*** | ***Date*** |

| Name:<br>Address: | Phone:<br>Relationship: |
|---|---|
| Name:<br>Address: | Phone:<br>Relationship: |

(con'd)

| Primary Physician:<br><br>Address: | Phone:<br>Fax: |
|---|---|
| Preferred Hospital: John R. Oishei Children's Hospital | |



Specialists

_______________________________________ Phone: ___________________

_______________________________________ Phone: ___________________

_______________________________________ Phone: ___________________

_______________________________________ Phone: ___________________

_______________________________________ Phone: ___________________

Please list any allergies: ______________________________________________________________

| Medicaid ID#: | Private Insurance: | ID: |
|---|---|---|

Case Management Services/Service Coordinators:

Agency:

Name:

Phone:

**(SIGN BOTH AREAS)**

I authorize the staff of CHC to provide or obtain emergency medical care for my child.

________________________________ ____________________ __________________________

Signature Date Relationship

I authorize the staff of CHC to exchange information with my child's primary care physician and emergency medical care providers.

________________________________ ____________________ __________________________

Signature Date Relationship