CHC LEARNING CENTER
A Program Of The Center For Handicapped Children, Inc.
1085 Eggert Road
Amherst, New York 14226
Voice: (716) 831-8422
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EMERGENCY CARE CONSENT FORM

July 1, 2023 - June 30, 2024

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: (If different from student)	Address: (If different from student)
Home Phone: (If different from student)	Home Phone: (If different from student)
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
E-Mail Address: (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: Address:	Phone: Relationship:
Name: Address:	Phone: Relationship:

(con'd)

Primary Physician: Address:	Phone: 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