



Parent Authorization and Consent

Child's Name: _____ Date of Birth: _____ Date of Enrollment: _____

Please initial next to each item that you authorize your child to use/participate in:

____ Pacifier when sleeping (infants/toddlers only) ____ I do not wish my child to use a pacifier when sleeping

____ Cot during rest periods or when not feeling well

____ Water play

____ Sunscreen (non-aerosol only)

____ Lip balm

____ Diaper Cream (as a preventative only. Once there is a rash or broken skin a doctor's note is required)

____ Lotion

____ I understand that all items must be labeled with my child's first and last name

____ For emergency purposes, we have permission to evacuate your child from the premises.

I hereby authorize The Meadows® to release my child to the following persons (other than parents):

Name: _____ Relationship: _____

Address: _____ Telephone #: _____

Name: _____ Relationship: _____

Address: _____ Telephone #: _____

Name: _____ Relationship: _____

Address: _____ Telephone #: _____

Please note **all** conditions for which the child is currently receiving treatment: _____

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for **The Meadows at The Meadows** (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective for one year.

Signed this _____ day of _____, 20____.

Printed Name: _____

Parent / Legal Guardian Signature: _____