



Creative Learning Center

For Very Young Children
1828 Chapel Street
Winston-Salem, NC 27127
Phone/Fax 336-773-0017

Medical Release/Consent for Treatment

We/I hereby give authorization and consent for the rendering to our/my child, _____, by a licensed physician, such medical services and treatment as may become necessary or advisable during the time our/my child is in the care of Creative Learning Center, regardless of whether such treatment or services become necessary by reason of an emergency, unanticipated conditions or otherwise. Such consent and authorization shall include also the cooperation and assistance of any qualified medical personnel working under the supervision of licensed physicians.

We/I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on our/my child's condition.

We/I hereby acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered.

We/I hereby give authorization for the use of 911 medical services for immediate treatment and transportation in emergency situations..

In case of emergency, we/I would like for my/our child to be cared for at _____ Hospital in Winston-Salem.

Child's Name: _____ Date of Birth: _____

Date of Last Tetanus: _____

Child's Physician: _____ Phone: _____

Address: _____

Please note: the signatures of both parents are required.

Signed: _____ Phone: _____
(Mother or legal guardian) (home) (work)

Signed: _____ Phone: _____
(Father or legal guardian) (home) (work)

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This form will be taken on all field trips.

Persons to contact if Parent or Guardian cannot be reached:

First Contact:

Name: _____ Phone: _____

Address: _____

Relationship to Child: _____

Second Contact:

Name: _____ Phone: _____

Address: _____

Relationship to Child: _____

CHILD'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT(S)

1. Is child allergic to anything? _____ If yes, please describe allergies _____

 2. Is child currently under a doctor's care? _____ If yes, please indicate reasons _____

 3. Is child on any continuous medications? _____ If yes, please describe _____

 4. Has child had any previous hospitalizations or surgery? _____ If yes, when and for
what reason? _____
 5. Is there any history of significant previous diseases/recurrent illnesses? _____ If
so what and when? _____
 6. Does child have any disabilities or developmental delays? _____ If so, please describe

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