FAMILY DAY HOMES
CHILD'S EMERGENCY MEDICAL AUTHORIZATION

Name of Child_____ Date of Birth _____

Name of Parent(s) or Gaurdian _____

Home Address _____

Place of Mother's Employment _____

Address _____

Telephone (home, cell, and work)_____

Place of Father's Employment _____

Address _____

Telephone (home, cell, and work)_____

The parent(s)/guardian authorizes _____
Name of Licensed Provider

To obtain immediate care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to his/her child if an emergency occurs when he/she cannot be located immediately.

It is alos understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses

   _____

2. Medical treatment costs are covered by:

   a. Medical Insurance
      Name of Insurance Company:_____

      Identification Number: _____

      Group Number: _____

   b. No Insurance: _____

Child's Physician_____Telephone _____

Address _____

_____

This form is to be kept by the licensed family day provider and is to be taken to the doctor or treatment facility in case of emergency.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
032-05-338/4 (8/00)

MEDICATION AUTHORIZATION

Prescription and non-prescription drugs, including vitamins, sunscreen, diaper ointment, and insect repellant, may be given to a child only with the parent's or guardian's written consent. Prescription medication may only be given by a caregiver that has successfully completed Medication Administration Training ("MAT").

Child's Name: _____ Date: _____

_____ has my permission to administer
(Provider's Name)

the following drugs and medication:

Medication and/or Prescription Number: _____

Dosage: _____ Time(s) to be given: _____

Special Instructions: _____

_____

> This authorization is effective from: _____ to: _____

> Parent or Guardian signature: _____

DATE	TIME	MEDICINE/DOSAGE	STAFF