Scamps

Emergency Medical Treatment Form

Child's Name	
Date of Birth:	
Doctor's Name:	
Doctor's Address:	
Doctor's Telephone Number:	
Allergies:	
Any other relevant medical information (i.e.: Allergies, Family Medical History):	
Parents / Carers Name:	
Address:	
Emergency Contact Number:	
Child's Medical Number:	

In the event that my child is involved in a serious incident while at Scamps, I expect the Manager, or a delegated member of staff, to contact me immediately on the above emergency contact number.

In the event that my child requires immediate treatment before I will be able to get to the Hospital, I hereby authorise the Manager, or a delegated member of staff, to consent to emergency medical treatment on my behalf.

I understand that this authorisation will remain valid unless I contact Scamps to withdraw it.

Signature of Parent / Carer:		Date:	