

AS THE PARENT, AGENCY REPRESENTATIVE OR LEGAL GUARDIAN, I HEREBY GIVE CONSENT TO  
**Upward Bound Preschool** TO PROVIDE ALL EMERGENCY DENTAL OR MEDICAL  
CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER  
WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF MY  
DEPENDENT. THIS CONSENT ALSO AUTHORIZES **Upward Bound Preschool** my  
APPROVAL FOR NEEDED MEDICAL TRANSPORT BY AMBULANCE OR HELICOPTER.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/AGENCY REPRESENTATIVE/GUARDIAN SIGNATURE

HOME ADDRESS

HOME PHONE

( )

WORK PHONE

( )

LIC 627 (1088) (CONFIDENTIAL)

Should an emergency arise, it is understood that a conscientious effort will  
be made to locate me or \_\_\_\_\_  
(someone other than parents)

\_\_\_\_\_  
(address) / \_\_\_\_\_  
(work # and home #)  
\_\_\_\_\_, before any action will be taken.  
(relationship to your child)

I accept full responsibility for any and all expenses for the medical care  
given my child in my absence. I do understand that there is medical  
insurance coverage for my child under the preschool's policy, and that  
the school's policy will be billed first.

PARENT'S SIGNATURE : \_\_\_\_\_ DATE : \_\_\_\_\_

OUR PRIVATE INSURANCE CARRIER IS : \_\_\_\_\_

POLICY # : \_\_\_\_\_ SUBSCRIBER'S NUMBER : \_\_\_\_\_

ADDITIONAL INFORMATION : \_\_\_\_\_

\_\_\_\_\_