**EMERGENCY MEDICAL / DENTAL TREATMENT CONSENT**

**I give permission for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to have Emergency Medical/Dental care if I cannot be immediately contacted. This consent is to be kept with the Emergency Contact Report information.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**